AN INVESTIGATION OF THE IMPACT ON THE NURSE LECTURER OF THE TRANSFER OF NURSE EDUCATION INTO HIGHER EDUCATION

'From Nurse Tutor to Nurse Lecturer'

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Signature ..... Coad .....

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The essence of creativity comes from thinking outside the framework…..

Einstein 1921

Abstract

The aim of this study was to explore perceptions about nurse teacher role attributes during the transition of nurse education from the colleges of nursing in the National Health Service (NHS) into higher education institutions (HEIs). The purpose was to make recommendations for practice that may be used to understand and develop the role of nurse lecturers in the future.

The principles of ethnography were used to review the role of nurse teachers as they transferred from 'Nurse Tutors' in colleges of nursing to 'Lecturers in Nursing' in HEIs. Data were collated by methodological triangulation, which included interviews and questionnaires. Perceptions of the nurse teachers' role were explored, by interviews, with a sample of fifteen nurse teachers before, at and after the transfer from one college of nursing into one university. Perceptions about the impact of the merger from the perspective of twenty qualified clinical nurses were sought after the merger. The qualitative interview findings were used to develop a questionnaire, enabling the views of nurse lecturers (n=98) across two other universities in the U.K. to be explored.

The overall findings indicated that whilst the majority of nurse lecturers had settled into their roles as lecturers in higher education after one year, some did not understand the organisational culture within which they worked. The findings raise issues pertaining to role adaptation and questions whether some aspects of the nurse lecturer's role have changed significantly since relocation. This has implications for the future planning when developing the nurse lecturer role. The findings indicate a need for further work in the field, as to date there are a limited number of studies that have considered the ways in which organisational culture impacts on the nurse lecturer role in practice.

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Abstract
Acknowledgements
Table of contents
List of tables
List of figures

Table of Contents **Page**

Chapter 7 Stage 1 Findings

Chapter 8 Stage 2 Findings

Chapter 9 **Stage 3 Findings**

Chapter 10 **Stage 4 Findings**

Chapter 11 Discussion and recommendations

List of Tables

Table List continued **Page**

Table list continued **Page**

List of Figures

Chapter 1

Introduction and aims of the study

1.1. Introduction

The study reported explores perceptions about nurse teacher role attributes during the transition of nurse education from the colleges of nursing in the National Health Service (NHS) into higher education institutions (HEIs). In order to achieve the aims key organisational cultural theory was used to underpin the work. Given the literature and little primary research found in this field, it was decided that the most appropriate approach would draw upon exploratory methods. The overall research design used methodological triangulation, underpinned by the principles of ethnography over a two-year time frame, so that the researcher could explore perceptions of experiences and feelings over a period of time.

1.2. Rationale

Nurses represent the largest proportion of the NHS workforce. In the last ten years, major social, political and technological change has had immense impact on the way that nursing is delivered. Consequently, educating this section of the workforce is vital to the future of healthcare in the U.K. As the nurse lecturer is central to this delivery it is important to have a greater understanding of this role. Moreover, it is essential that if professional roles are to develop they need to be continually reviewed (Biddle & Thomas 1966).

There has been major changes in the way that nurse education is funded and delivered. These changes have included the transfer of nurse education from the auspices of colleges of nursing based in the NHS into higher education institutions (HEIs). It was anticipated that a change of such magnitude would have impact on the people involved, including those delivering the service, such as nurse teachers. One notable impact was that the merger into higher education resulted in the nurse teachers transferring contracts, and changing roles from 'nurse tutor' to that of 'lecturers in nursing' or 'nurse lecturer'.

It may be argued that there are many similarities between the NHS and HEIs. Indeed, both are large public sector organisations, are a major employer and offer key public services to different sectors in society. However, whilst there are many similarities and commonalties, there are different philosophies and ways of delivering services. Furthermore, although there exists a body of literature pertaining to the nurse teacher role it should be noted that most of those studies were performed in colleges of nursing prior to the merger (Jeffree 1991, Crotty 1993, Baillie 1994, Luker at al 1993, Clifford 1995a, Carlisle et al 1997). These studies clearly highlighted that the nurse teacher role is complicated, ill defined and multi-faceted. Although all these issues are analysed in the literature review, some will be outlined briefly below to set the context for this study.

There have been several literature reviews and commentaries about the possible effects of the merger of nurse teachers working in the culture of colleges of nursing based in the NHS into HEIs. However, these tended to focus on the process of integration and strategic policy (Ball 1998, Green 1994, Draper 1996 and Rodriguez & Goorapah 1998). Evers (2001) undertook a detailed analysis of all the Royal College of Nursing (RCN) education-based conferences over 2000 and 2001 to find that only twelve abstracts focused on the nurse teacher role.

For this study, a comprehensive review of primary research was undertaken with respect to the impact of the merger into higher education on the nurse teachers' role. This highlighted that limited work had taken place (Day et al 1998, Barton 1998, Evers 2001, Clifford et al 2001). If nurse teachers are to develop their roles in HEIs as part of a culture to establish nursing as an academic discipline in the United Kingdom (U.K.) there is an urgent need to investigate this from both the perspective of the individual (micro) level and the organisational (macro) level. In addressing this deficit this study has been developed as outlined in the Section 1.3 and presented here in Table 1.1.

Table 1.1. Overall design of the study

Stage 1 (pilot)

Interview pilot study involving semi-structured interviews with 2 nurse teachers, 2 students, 2 clinical nurses and 1 university lecturer prior to the merger of nursing colleges into higher education.

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Analysis of interview transcripts

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Development of interview tool and codes created

Stage 2

In-depth exploratory interview with a group of 15 nurse teachers using a longitudinal framework (x 45 interviews)

- **Stage 2a** - 3/12 prior to the merger in one college of nursing in the NHS.
- **Stage 2b** - at the 'merger point' into one HEI.
- **Stage 2c** - 12/12 months after the merger into one HEI.

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Analysis of Stage 2a, 2b and 2c interviews

Stage 3

Interviews with a group of 20 clinical nurses one year after the merger from colleges of nursing into higher education

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Data Analysis of Stage 3 interviews

Stage 4

Questionnaire designed from interviews of Stages 2 and 3. Includes:

- Stage 4a – Pre-test of questionnaire
- Stage 4b – Survey using a sample of nurse lecturers (n=140) in two other HEIs, one year after the merger.

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Data Analysis of Stage 4 questionnaires (informed from interviews) x 98

1.3. The context of the study

The aims of the investigation were to:-

(i) Explore perceptions of the nurse teachers' role as they move from working as nurse teachers in colleges of nursing in the National Health Service (NHS) to working as 'nurse lecturers' in HEIs.

(ii) Explore the impact on the role attributes of nurse lecturers as they develop their new roles in higher education from both an individual (micro) level and the wider organisational culture (macro) level.

(iii) Explore the perceptions of clinical nurses in relation to the nurse lecturers' role as a result of nurse education transferring into higher education.

(iv) Make recommendations about the nurse lecturer role that may be used to understand the role more clearly.

In order to achieve the aims of the study reported four stages were used.

1.3.1. Stage 1

The pilot study, which involved a series of semi-structured interviews with two nurse teachers, two students, two clinical nurses and one university lecturer prior to the merger of one nursing college into one higher education institution (HEI).

1.3.2. Stage 2

In-depth exploratory interviews were conducted on the same group of 15 nurse teachers on three occasions over 15 months (x 45 interviews). This was undertaken

whilst nurse teachers were in colleges of nursing in the NHS, immediately after the merger into higher education and twelve months after their transition in one HEI. Stage 2 was broken down as follows:

- **Stage 2a:**
  Three months prior to the merger into higher education when the nurse teachers were employed within one college of nursing in the NHS

- **Stage 2b:**
  At the 'merger point' when staff from one college of nursing in the NHS transferred into one HEI.

- **Stage 2c:**
  Twelve months after the merger into one HEI had occurred.

1.3.3. Stage 3

Interviews with a group of 20 clinical nurses to ascertain their perceptions of the nurse teacher role following the transition into higher education. These interviews took place in three hospital trusts (Hospital A, B and C) one-year after the merger into higher education for their perceptions about the nurse teacher role.

1.3.4. Stage 4

The qualitative interview findings from Stages 1, 2 and 3 were used to develop a questionnaire for use one year after the merger into higher education to obtain their views about the nurse lecturer role in HEIs. The questionnaire was pre-tested in a pilot study (Stage 4a) prior to a survey of nurse lecturers (n=140) in two universities (University B and C) in the U.K (Stage 4b).

1.4. Background to the study

The literature review process of this study will be discussed elsewhere (Chapter 2; Section 2.1). This was organised into four chapters. Firstly, the historical context of nursing and nurse education will be explored using the many reports and influences which have precipitated the current changes related to nurse education. The review highlights the impact of a service-led nurse education that dominated many nursing developments and initiatives. Secondly, key literature pertaining to the concept of role is drawn upon and work that has related role theory to nursing education will be reviewed. A comprehensive review of key literature seeks to highlight that the nurse teacher role was complex, multi-faceted and unclear before the merger into higher education (Sims 1976, Crawshaw 1978, Gallego et al 1980, Sheehan 1981, Stephenson 1984, Jones 1985, Nolan 1987, Gerrish 1992, Davies et al 1996, Cahill 1997, Clifford 1992, 1993, 1995, Luker et al 1993 and Camiah 1996). The limited number of studies that have explored the role of nurse teachers following the merger into higher education will also be analysed (Day et al, 1998, Barton 1998. Clifford et al 2001 and Evers 2001).

One outcome of the merger into higher education was that nurse teachers changed their title from that of 'nurse tutor' to that of 'lecturer in nursing' (or nursing lecturer), and whilst there was some recognised common conceptual understanding, there was also misunderstandings related to title and associated role. Therefore, in the third chapter, the term of 'teacher' and surrogate term of 'lecturer' were

analysed in the form of a concept analysis in order to relate this to the role held by nurses teaching in HEIs today.

Throughout the review the impact on role change lies with a broad recognition that the organisational culture of the NHS differs from that in HEIs. Therefore, the final chapter focused on the impact of organisational change on the role of nurse teachers as a consequence of the merger of nurse education from colleges of nursing in the NHS into HEIs. Models of organisational cultural theory reviewed were found to be useful. It was interesting to note no previous studies in nurse education were found that used such a framework.

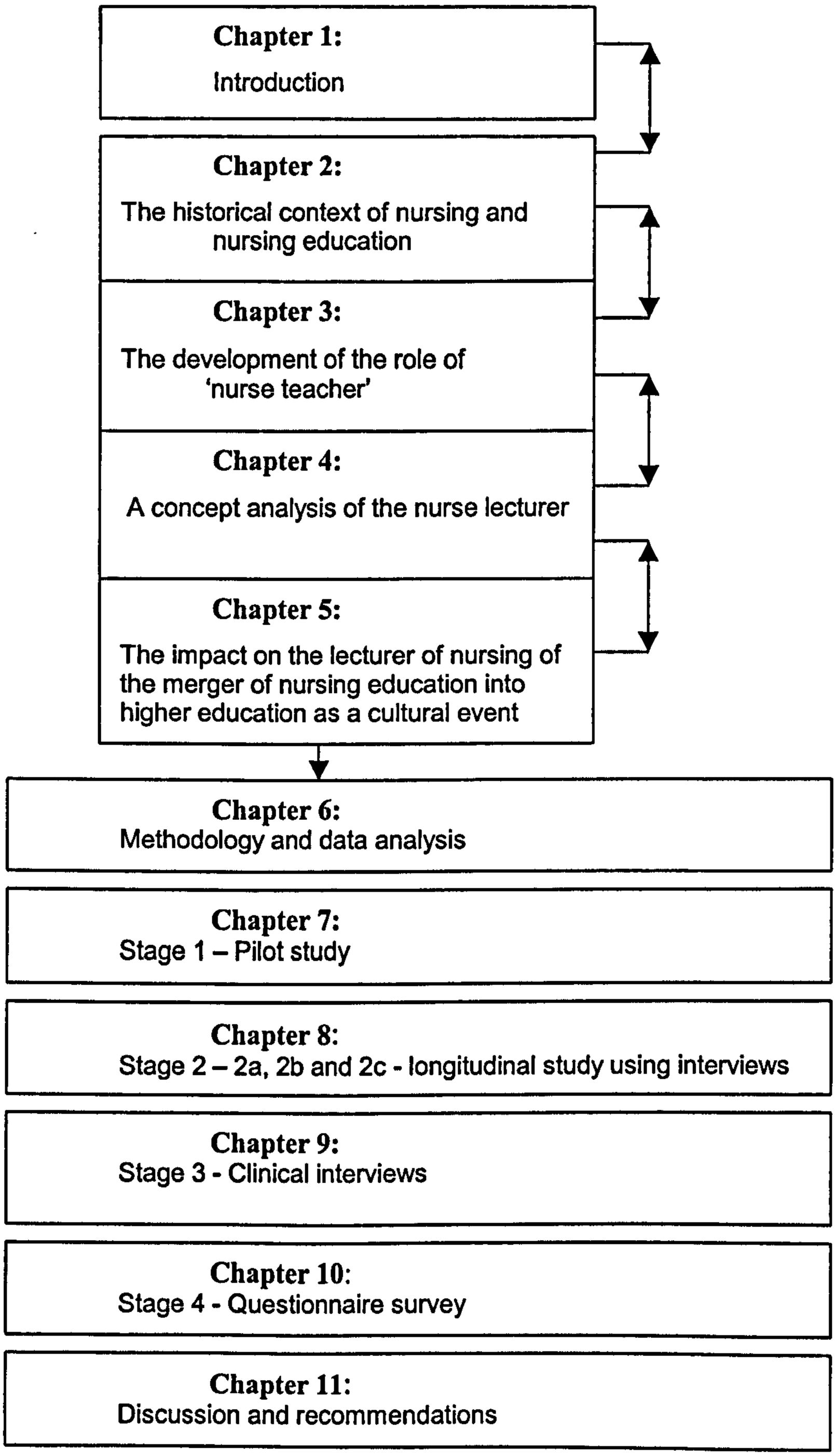
One model devised by Sackmann (1991), largely used in industrial/business merger events was found to be useful. Application of this to the study reported helped as NHS colleges merged into HEIs at a time when both education and the health service were affected by the changing policies and competing priorities of resource allocation. Thus, Sackmann's (1991) framework, helped to set the scene about nurse education from a organisational cultural perspective and served to highlight that nurse teachers were at the crossroads of cultural change.

1.5. Structure of the study

The structure of the thesis is outlined in Table 1.2. Each chapter aims to demonstrate the progression of the study. In writing the report, one aspect that needed much consideration was the title to use for the study group. A decision was made that in the majority of chapters the title 'nurse teacher' would be used (Chapters 2 to 8). The reason for this was to ensure a universal meaning was used during all the stages whilst nurse teachers evolved from 'nurse tutors' to 'nurse lecturers'. Once Stage 3 and 4 are reported, the title of nurse lecturer is used, as this represented the titles adopted in HEIs and what nurse teachers are currently known as. Therefore, Chapters 9 to 11 use the title of nurse lecturer exclusively.

Overall, the findings in this study were very interesting from both the nurse teacher role at an individual (micro) level and the wider organisational culture (macro) level. Findings indicated that nurse teachers had entered a career in education because they 'enjoyed teaching' and that they felt that nurse teachers were in a prime position to teach the theory that underpins nursing. However, the merger in HEIs created much anxiety and the nurse teachers were not fully prepared for their new roles in higher education culture. Additional problematic issues related to the nurse teachers titles, uncertainty of expected role, clinical issues, role autonomy, communication, work isolation and administration and managerial duties.

Table 1.2. Outline of the thesis



At the end of the study, whilst findings indicated that the majority of nurse teachers had settled into their roles as lecturers in higher education, some of the nurse teachers did not understand the organisational culture within which they worked. Such differences were disturbing and strongly indicated that all the parties concerned should give serious consideration to the shared vision in the future planning of the nurse teacher role. The study concludes that there is a need for further work in the field, to facilitate the sharper integration and role development of nurse teachers working in higher education.

On reflection, the framework used in the study was useful in mapping the nurse teacher role from both the perspectives of nurse teachers and clinical nurses. Reviewing role attributes from an organisational cultural perspective has generated a wealth of new knowledge about the role of nurse teachers as they evolved into lecturers in nursing as a result of nurse education transferring from colleges in the NHS to HEIs. Indeed, this study has highlighted the complex role of nurse teachers now that they are 'lecturers' within the organisational culture of HEIs. It is hoped that the insights gained will be useful for future recruitment and retention of staff. Therefore, the findings and recommendations from this study have not only implications at the micro level of the nurse teachers role but from the macro level of the organisation. In generating new knowledge about the role of nurse teachers as they evolve in lecturing posts in HEIs, it is hoped that this will have implications not only for nurse teachers but also those who work alongside them and the students whom they teach.

Chapter 2

Literature Review

2.1. Introduction to the literature review

Over the last ten years there has been much concern that nurse education has fallen short of meeting the demands put upon nurses working within the current climate of the NHS. In order to address such shortfalls, the government supported a radical reform of nursing education systems, which included the merging of nursing colleges located in the NHS into HEIs. An integral part of the merger were the staff working in the colleges of nursing and more specifically to this study the nurse teachers working as 'Nurse Tutors' who transferred to the university as 'Lecturers in Nursing'. Investigations surrounding the nurse teacher role in HEIs in the United Kingdom (U.K.) are limited but this information is essential if models for optimal role performance are to be achieved.

A general search using Cumulative Index and Allied Health Literature (CINAHL) spanning the U.K. and international studies the last twenty years was undertaken. This revealed a wealth of literature pertaining to the key words of 'nurse teacher' and 'nurse education'. This highlighted that although the nurse teacher role had been examined from differing angles, it had not been examined from the impact of the transfer of nursing from colleges of nursing in the NHS into higher education. The search was widened to include references surrounding organisational merger

events that had occurred with other professionals in other organisations. This highlighted a breadth of material about organisational culture and merger theory.

To extend the literature a review of the 'grey literature' was also used in one locality in the U.K. Grey literature is a form of literature whereby sources such as research reports, committee meetings, working papers and unpublished dissertations are acceptable in informing the work (EAGLE 2000). Such sources contain useful comprehensive information and were helpful in focusing the study reported here.

The literature and information was collated and read extensively until a 'picture' began to emerge (Bell 1993). As a consequence, themes emerged which will be used to direct the review and are as follows:

- Historical Context of Nursing and Nurse Education
- The development of the role of 'nurse teacher'
- A concept analysis of the Nurse Lecturer
- The impact on the lecturer of nursing of the merger of nursing education into higher education as a cultural event

2.2. The Historical Context of Nursing and Nursing Education

This section of the chapter provides an historical and contextual overview of the development of nursing in order to locate the changes in nurse education. The inclusion of such material aims to demonstrate that nursing and nurse education has been slow to change and is therefore a product of its history.

2.3. The Historical Context of Nursing : Pre 1900s

Although there has been much previous well-documented evidence on the history of nursing and nurse education it is important to set the scene for this study. In examining the issues relevant to nurse education it is pertinent to establish what the discipline of nursing actually entails. On this there has been much deliberation, but the word 'nurse' derives from the Latin root *'nurtrire';* to nurture or cherish (Calder 1965 pp9). Henderson (1966) added that nursing is concerned with the care of all well and sick people, young and old, rich and poor wherever they may be. It is also clear from the literature that the discipline of nursing has slowly evolved from the traditional role of women who often commanded 'matriarchal' positions in the group or family. In short, whilst the men were away hunting for food the women stayed at home to care for the children and it was they who were responsible for the care of the sick (Calder 1965).

This is a common misconception, however, as men were acting in the role of nurse in Ancient Greece, in Europe until the reformation of the church and during the crusades as the Knights of Hospitallers of Saint John (Davies 1980). Therefore, it is worth considering why nursing evolved into female dominated work.

With the reformation of the Christian church it was women, in highborn positions, who began to undertake the caring of the sick and who became known as 'Deaconesses'. A number of charity based hospitals emerged for example, in London, St. Bartholomew's Hospital was founded in 1123 followed by St. Thomas's Hospital in 1215. In 1638, with the support of the charity worker, St.Vincent de Paul, a deaconess, Mademoiselle de Gras reorganised the work force from wealthy countrywomen to women of a peasant class 'training' them to care for the sick in their own homes (Calder 1965).

Such developments are undoubtedly at the foundations of formal nursing, but Maggs (1987) notes that any discussion surrounding the history of nursing is most noticeably witnessed during the 1800's onwards. It was in the early 1800's when women who were domestic servants began to dominate nursing care and were renowned for their ignorance, laziness, low morals and hardmindedness (Davies 1980). Germarnikow (1978) suggests that on one hand there was a celebration of woman as carers, but at the same time this was the first stirring that women could fulfil important social functions.

Other events were also relevant at this time. In 1834, with the advent of the Poor Law Act people who were destitute were given relief via the workhouse and 'Poor Law Nurses' who were exclusively female, hardworking and amenable to discipline subsequently cared for the sick (Davies 1980). Thus this group was considered to be in a position of low status and deemed as ignorant, even dangerous (Germanikow 1978, White,1978). Whilst Baly (1995) argued that this was the foundation of Britain's first nursing service, Maggs (1987) disputes this emphasising that the name of nurse did not carry with it any kudos but rather was held in low regard and even contempt. It is arguably harsh but as a consequence Calder (1965 pp45) referred to this period as the 'Dark Ages' in the history of nursing.

It was not until 1848, with the work of social reformers such as Elizabeth Fry that the plight of the sick poor was highlighted. In addition, as part of the social reform of the 18th century, Florence Nightingale returned from the Crimean War to commence The Nightingale Fund (based at St. Thomas's Hospital, London) to train young middle class women to be 'nurses' (White 1978, Davies 1980). Other hospitals across the United Kingdom (U.K.) also began to develop their own internal training programmes but it is frequently Florence Nightingale through her famous *'Notes on Nursing'* who is given the most credit for her development of nursing. However, Dingwall et al (1988) suggest that Florence Nightingale's contribution to nursing is difficult to critically review as largely writings about her feature on 'mythical' as opposed to historical information. Nevertheless, although

Nightingale made a major contribution to the evolution of nursing arguably this was limited in two specific issues.

Firstly, Nightingale largely advocated that nursing should be an all female profession exemplified in her *Notes on Nursing* where she states ' To be a good nurse; you must be a good woman' (cited in Davies 1980). Mackintosh (1997) suggests that as a result nursing was perceived as a suitable career for women, as it was an extension of work undertaken in the home and this was indeed exploited by middle-class women like Florence Nightingale. Consequently, he argues that such views did irreparable damage to nursing recruitment and the reason why a large proportion of nurses are still female. Baly (1995, pp42) supports such arguments noting that this also resulted in the creation of other stereotypical attitudes about nurses being caring, 'saintly' or 'motherly' in their duties.

The second contentious legacy of Florence Nightingale surrounds the issue of registration of nurses on a national register. As indicated in the late 1800's women were working as 'nurses' in 'Nurse Training Institutions' (NTI) but a formal register did not exist across the U.K. Interestingly, Florence Nightingale fiercely opposed the notion of nurses being formally registered on a national register, which resulted in conflicting views with other notable nursing reformers such as Mrs Bedford-Fenwick (Bendall & Raybould 1968). Because of Florence Nightingale's powerful influence it was not until after her death that a national registration took

place and the General Nursing Council (GNC) was subsequently established in 1919 to oversee the training of nurses.

2.4. Historical context of nurse education: 1900s –1970s

In 1904, a select committee of the House of Commons was set up to examine and report on nurse training. This committee had recommended that there should be two levels of training, one with less academic emphasis than the other. No action was taken from these recommendations until in 1919, the General Nursing Council (GNC) was established and a process began whereby prospective nursing schools sought to be approved training centres affiliated to local hospitals. Thereafter, nurses who undertook a GNC approved pre-registration training programme were able to register on a national register. Such nurse training programmes included a clearly defined syllabus, assessment of practical skills and a final written examination that all nurses had to pass and were so tightly managed by the GNC, that there was little difference between one school of nursing to another (Bendall & Raybould 1968).

Initially, one level of training programme was identified. Those who completed this successfully were known as State Registered Nurses (SRN), after which they could seek qualified nursing positions (Davies 1980). The registered nurse programme was predominantly an apprenticeship with the majority of learning occurring through 'hands on' experience with the emphasis being on training rather than professional education. Prior to formal GNC approved programmes the length of

training varied immensely from one year to three years, the standards of which being dictated by the matron of the particular institution (Abel-Smith 1960). The GNC introduced a standardised training, in which all registered nurse training across the U.K. was set at three years in length. However, Dingwall et al (1988) argue that although the GNC mapped out the registration of nurses they had very little power as central government and the service led employers retained control.

This pattern of registration remained until 1940 when there became a demand for 'more hands on nurses by the bedside'. Subsequently a two-year programme was developed, the nurses qualifying from this programme being known as State Enrolled Nurses (SEN) (Abel-Smith 1960). The SEN academic entrance was lower, their training was two years and they received less theoretical instruction during their course than the SRN who received three years. Such a training programme was viewed as innovative and appeared to fill a recruitment gap.

Parry and Cobley (1995, 1996) in reviewing the SEN programme argue that it came with many problems. Firstly, at the bedside there had always been 'Ward Helpers' who undertook caring / housekeeping duties and known as 'Nursing Auxiliaries'. A proportion of these took the opportunity to train as a SEN, however, others were simply awarded the SEN qualification as part of a long service reward and became qualified without having undertaking any official training. Parry and Cobley (1995) note that some animosity occurred in the profession that was subsequently detrimental to the SEN. Secondly, Parry and Cobley (1996) suggested that on

qualification many SENs' worked predominately in the practice setting could not enter into senior managerial or educational posts. As a consequence the model of two-tier training became based on elitism and hierarchy, and left 'scars on many SENs' (Parry and Cobley 1996 pp45).

The development of the two programmes did not alleviate the recruitment problem, which was highlighted firstly in the Lancet Commission (1932) and later in the Nursing Reconstruction Committee report (RCN 1949). Each report advocated that nursing morale was low and that the apprenticeship style of training had to be discontinued replacing it with a style of training where student nurses were 'supernumerary' in clinical areas. The reports suggested that nursing schools should function independently of the hospital service and that the trainees who received a service-led salary should be acknowledged as students. In this way the students would receive a bursary or grant, receive professional education for a significant part of their training and would thus, receive the 'status' and 'freedom' as other professional students. However, one of the main difficulties in implementing the concept of 'student status' was the chronic shortage of nurses and so both reports failed to make any substantial impact.

Following the Second World War and with the formation of the National Health Service (NHS 1946), the picture began to change as nursing began to gain in popularity as an occupation (Abel-Smith 1960). At this time, the system was divided into regional/district system of hospitals and specialist services; primary

care services of medicine (General Practice), dentistry, pharmacy and optometry; and the community/public health services of the counties and county boroughs (NHS 1946). At the same time social changes were occurring such as an increased focus on community care, age composition, life expectancy, gender changes, patterns of illness and greater public awareness (Abel-Smith 1960).

However, commissioned research by Platt (RCN 1964) threw further doubt on the service-led model of nurse education. This report aimed to re-define nursing education through the instigation of new patterns of nurse training designed to improve recruitment and thus impact on patient care. It also highlighted that there was still a chronic shortage of people entering nursing. Not only this, research by Revans (1964) found that nurse employees had ineffective communication channels, low morale and as a consequence there existed problematic differentiation of working roles at all levels, indicating problems with ensuing standards of patient care. Such findings were viewed by many nurses as a huge threat, but to others came as little surprise as this had been previously reflected in several other key reports including Athelone (Ministry of Health 1939) and The Nursing Reconstruction Committee (RCN 1949).

Such issues did not disappear and in 1972, the Briggs Report was commissioned by the Secretary of State for Social Services; the aim being to 'review the role of the nurse and midwife in the hospital and the community ...and the education and training required for that role, so that the best use is made of available manpower to meet the present needs of an integrated service' (DHSS 1972 pp2). The main

findings concluded that nursing was the largest group in the NHS and was viewed as one of the major caring professions requiring a range of skills rather than a number of jobs to be performed.

Some of the major recommendations of the Briggs Report (DHSS 1972) included:

1. Colleges of nursing should be formed each with their own principal, own staffing arrangements and own budgets.

2. Entry to the training of nursing should commence with aptitudes of intelligence as well as 'O' Levels and that training facilities should include attractive packages for mature entrants.

3. The first 18 months of training should lead to a Certificate in Nursing Practice and the final 18 months of specialist nursing should result in registration with as Higher Certificate.

4. SEN training programme should be phased out.

5. A single statutory body for professional standards of education should be implemented supported by three distinct boards for England, Scotland and Wales.

6. Better communication and counselling services for all nurses.

7. Better support for nurses to undertake continued study after qualification.

8. The development of more patient-structured services at ward level.

Although such issues had been previously identified in other reports the Briggs Report arguably raised much optimism in the profession that a major change in nursing and nurse training would occur (White 1978). However, there were certain dangers in the urge to confront such long-standing values and there followed years of uncertainty and discussion as to how to develop the skills of nurses in the clinical

setting against the backdrop of continued preference to the service requirements. Thus the majority of student nurses continued to be 'trained' in schools of nursing within the NHS and so continued as employees of the Health Authorities rather than being given a full student education and status in higher education institutions (Dingwall et al 1988). All of the issues highlighted remained the norm until the beginning of the 1980's when a period of rapid change began.

2.5. Historical context of Nurse Education: late 1970s – 1980s

The General Nursing Council was replaced in 1979 by the United Kingdom Central Council for Nursing and Midwifery (UKCC) which included the replacement of all the previous statutory bodies responsible for nursing, midwifery and health visiting (Davies 1980). The UKCC aims to set standards for nursing and midwifery education, regulate professional conduct and oversee the work of four separate national nursing boards within the countries of England, Scotland, Northern Ireland and Wales. The national boards were largely organised by appointed members who were directly elected by the profession; a model which was utilised until 1992 when amendments were made to legislation (Maggs 1987). As a result of legislation amendments the UKCC had elected members whilst the members of the national boards were appointed by government ministers. Although courses were 'approved' and regulated by the national boards, the actual curriculum planning and development was devolved to individual schools of nursing and freedom was given for innovation at a local level (Davies 1980).

Several reports emerged stating that pre-registration student nurses, whatever the level, should be supernumerary for a significant part of their training (RCN 1985, ENB 1985). The Royal College of Nursing commissioned Dr. Harry Judge (RCN 1985) to undertake a comprehensive survey method of number and geographical distribution of schools of nursing, the educational qualifications of entrants, wastage rates of students and examination results across the U.K. It concluded that, whilst 80% completed their training a further 20% were failing and this had to addressed. The key recommendation echoed the messages of the previously outlined Briggs Report (DHSS 1972) stating that 'nursing education must formally disentangle the education of nurses from the organisation of the services which nurses deliver'. Other recommendations concluded that nurse education programmes should be a three-year diploma level with two years of generic study followed by one year of specialist branch study and that the two-year SEN training must be phased out.

Arguably, a particular feature of the Judge Report (RCN 1985) is that it is easy to read and interesting to review as its content is in popular language. Dingwall et al (1988) note that this was indeed purposeful so that the general public would be able to read and understand the dilemmas that nursing faced at that time. However, the Judge Report's (RCN 1985) impact was arguably less than the Briggs Report (DHSS 1972), although Dingwall et al (1988) add that it did influence the UKCC through the later publication of the Project 2000 report (UKCC 1986),

At the same time the English National Board (ENB) (ENB 1985) published a consultation paper and although it was only a brief review of nurses training and largely supported previous work it added weight to the increasing criticism. One of its useful findings was to analyse the major difficulties in implementing any document as a result of balancing act between the needs of 'student status' against a shortage of nurses that existed at this time across the United Kingdom. The ENB (1985) and the Judge Report (RCN 1985) both called for a radical review to take place and that new ways of developing nursing as an 'attractive' career should be considered.

2.6. Historical Context of Nurse Education: 1980s –1990s

As highlighted, in the late 1980's a number of key reviews exploring the education and training of student nurses were completed (RCN 1985, ENB 1985). This paved the way for the ENB in their 1986 annual report, to support the development of six new pilot schemes leading to registration in nursing whilst also demonstrating clearer links with higher education (ENB 1986).

These pilot schemes varied in the style of innovation, with some schools of nursing adopting a clear supernumerary model with the award of a Higher Education Diploma whilst others followed a more traditional pattern (Clifford 1989a). Although graduate, university-based nursing courses had been established in the United Kingdom these students were a minority group (Moloney 1986). The

introduction of the Higher Education Diploma award resulted in closer affiliation with higher education and was the beginnings of a major shift in nursing education.

However, before the pilot schemes were fully evaluated a major reform of nurse education was endorsed by the government in the publication of 'Project 2000 – a new preparation for practice' (UKCC 1986). The title 'Project 2000' was used to indicate the difference between the 'new' and traditional nurse education programmes. Despite the lack of critical review, Project 2000 courses were firmly established by the late 1980's/early 1990's as the framework for all nursing education. The Project 2000 courses offered a new format that included the instigation of one level of pre-registration nurse (first level Registered General Nurse or RGN), therefore abolishing the SEN training programme. The students were to be based in higher education institutions (HEI), undertaking a three-year programme, 50% of which was theory-led, with a greater emphasis on health and the sciences of physiology, sociology and psychology and 50% was practice based content.

Although the length of programme remained three years the criterion was that the students would attend courses that were 'educationally led' in contrast to previous programmes, which were 'service led'. Therefore, it was intended that the students would spend more time undertaking scholarly activities in a college of nursing affiliated to a HEI (ENB 1996a). To facilitate commonality in learning it was proposed that the course would commence with a core or Common Foundation

Programme (CFP) of eighteen months where a general overview of nursing would be delivered. This was followed by a further eighteen months with the student's preferred 'branch' choice of Adult, Child, Mental Health or Learning Disabilities (UKCC 1986). The simple rationale was to move away from a model in which nurses trained initially, to be Registered General Nurses (RGN) and then accessed other training programmes after this resulting in many cases in duplication of learning (UKCC 1986).

The key to the change was that although the students remained in nursing colleges within the NHS all of the schemes formulated links with higher education and the nursing students on these programmes were awarded a nursing qualification and a Diploma of Higher Education on qualification (UKCC 1986). This indicated a considerable change for nurse education forming links into the mainstream of higher education (Kenworthy et al 1992).

Furthermore, as a mark of the changing philosophy students would receive a non-means-tested bursary rather than a salary and would be 'supernumerary' for the majority of their placements. This meant that nursing students would not be counted in the numbers of staff in the clinical areas and consequently several authors noted that the notion of 'educationally - led' student nurse training began (Kenworthy et al 1992, Barton 1998). Inevitably though, this resulted in massive change not only for the profession of nursing but also the education and training of student nurses (Chandler 1991a, 1991b, Jolley and Brykczynska 1993).

With the English, Scottish and Welsh National Nursing, Midwifery and Health Visiting Boards supporting the programme, 'supernumerary status' for student nurses gradually became a reality. Although the implementation of the Project 2000 programme across the UK was slow (by 1991 only 30 sites had begun the new system) an analysis of Project 2000 is important to reflect on some of the issues that came with this educational reform.

2.6.1. An analysis of Project 2000

The report Project 2000; A New Preparation for Practice (UKCC 1986) drew together widespread consultation which recommended that nursing should develop firmer links with institutes of higher education (RCN 1985). It initially received widespread support although midwives raised concern that in Midwifery, a Common Foundation Course was not required followed by a branch programme and so therefore retained their independence (Jowett et al 1992).

In changing the focus to the Project 2000 programme it was hoped that a different group of students would be attracted to nursing, for example mature students and school leavers wanting a course with additional higher academic qualifications (i.e. Diploma). To some extent this worked, but Jowett et al (1992) in a comprehensive report, noted that nursing education was still largely delivered in nursing colleges often away from the universities. In addition, Jowett et al (1992) found that Diploma Level nurses wanted to gain further qualifications and three-fifths of their sample stated that what they really wanted was a university degree. Therefore, they

concluded that the image of nursing would not significantly change until it was completely delivered and programmes organised in a HEI.

Any major change requires sufficient funding and in terms of financing the Project 2000 scheme the government via The Department of Health (DoH), after some deliberation, committed large amounts of money to its implementation. The actual total amount of money was unclear, but each college of nursing had to calculate the total projected costing of undertaking the course using a rather turgid and complicated formula. Data obtained for the review highlighted that one college of nursing in the West Midlands was awarded £2,500,000 (Mallaber 1993). However, even after financial commitments were secured Project 2000 programmes were not implemented without a multitude of concerns (Chandler 1991b).

Firstly, several key pieces of work noted that it was felt that the new 'Project 2000' nurses would want to move more quickly into research, management and education or even leave the profession for alternative careers (Owen 1988, Akinsanya 1990, Chandler 1991a, Jolley and Brykczynska 1993). Consequently, there was some resistance from nurses who felt that the Project 2000 programme was too focused in education (or theory-led work), as opposed to clinically led work 'at grass root' level where the majority of nursing care takes place (McElroy 1997 pp145).

Secondly, research studies evaluating the Project 2000 programmes highlighted that an eighteen-month CFP was too long. Two studies by Elkan and Robinson (1994) and Cash et al (1994) noted that during the CFP considerable time was spent undertaking 'theory led' activities in the classroom, some of which overlapped and that the clinical placements were limited. Norman et al (1996) also found that whilst students had preferences for their branch from the start the CFP was very orientated towards adult patients and hospital based care. Some students subsequently, therefore, entered their chosen branch after eighteen months to find that they were ill prepared with limited skill development.

It was suggested that qualified Project 2000 nurses would be able to work in any setting given an increased community focus (UKCC 1986). However, literature later emerged that student nurses experienced a lack of practical experience during their course. This was noted specifically in relation to the community setting, as Chandler (1991b) suggested that the newly qualified nurses were ill equipped to care for patients in the community due to their lack of practical experience and skills. Not only in the community settings, Maggs and Rapport (1996) also found that whilst Project 2000 nurses had many positive qualities, such as research awareness and good communications, they lacked practical nursing skills on qualification and were ill prepared to deliver care in many settings.

Further resistance was evident in the supervision and support of the students. Clifford (1989b), Kershaw (1990), Jolley & Brykczynska (1993) and White et al (1993) all purported that given the requirements of the Project 2000 programme, many existing qualified nurses expressed concerns about who would supervise and support the students. They also noted that from the perspective of mentorship of students during clinical placement, that the new Project 2000 students would require much more supervision time by qualified nurses. This brought with it new demands. Kershaw (1990) noted that registered nurses would be responsible for the individual student supervision and that they may find the supervising role very demanding and patient care could be inadvertently affected. Thus, as a direct response to the growing need for qualified nurses to meet such criteria, the UKCC and the National Boards developed a wide range of 'top up' courses such as the ENB 998 Teaching and Assessing course (Rye 1991, Kershaw 1990, White et al 1993, UKCC 1993, 1994).

Thus, Kershaw (1990) noted that resistance was inevitable and that resistant attitudes arose out of a lack of understanding about the details of the Project 2000 programme. Jolley & Brykczynska (1993) added that as a result of the Project 2000 nurses receiving a Diploma in a Higher Education when the majority of qualified nurses did not have higher education qualifications, they were viewed as a threat. In response to this, post-registration courses were developed including a range of part-time and full time courses ranging from Diploma to Masters degrees (Rye 1991).

In summary, Project 2000 signalled a clear need for reform of nurse education and emphasised the importance of demographic change in the UK which would mean the labour intensive health service competing for a shrinking population of school leavers. Project 2000 was without doubt a massive educational reform for nurse training programmes and built upon the foundations of the Judge Report (RCN 1985), but this programme required considerable organisational and funding arrangements for its implementation. Additionally, Miers (1997pp6) noted that whilst Project 2000 appeared to respond to the culture of the NHS it 'said little about the stakeholders'. It is essential therefore to highlight such issues within the contextual literature at this time.

2.6.2. The culture of the NHS – impact of policy on nursing and nurse education

At the same time as Project 2000 many other NHS reforms were taking place and in 1989 the introduction of a 'new' model of 'purchaser-provider' splits and the need for the development of primary services was highlighted. Calman (1998) noted that these changes dominated the health service, were the focus of intensive reviews and re-organisation of service delivery and so impacted upon educational provision. The documents precipitating such events require further analysis.

In January, 1989, The White Paper 'Working for Patients' (DoH 1989a) was published. This was to have a huge impact on health service delivery as it effectively withdrew statutory health authorities from their role as direct managers of care and instead gave them money to commission services from a range of

providers in an 'internal market'. In brief, the focus included issues such as efficiency and quality of care within the NHS. Two objectives were identified:

1. To give patients better health and greater choice of the services available.

2. Greater satisfaction and rewards for those working in the NHS who successfully responded to local needs and preferences.

The cited objectives were to be achieved through the re-structuring of the NHS both in terms of regional, district and family practitioner bodies. Firstly the delegation of 'power and responsibility' was to be devolved at a local hospital level and hospitals could, if so desired apply for 'self-governing' status as Trust Hospitals. These Trust Hospitals would offer and purchase services to and from different health authorities and the private sector creating an 'internal market'. At the same time General Practitioners (GPs) could apply to manage their own budgets. This was further developed in a later government White Paper published in November, entitled 'Caring for People: Community Care in the Next Decade and Beyond' (DoH 1989b). These papers built on the 'Working for Patients' (DoH 1989a), to re-shape the community care services. They advocated that GPs should be more independent acting as fund holders to purchase and contract for health care services with the provider units, hospitals and community services as required by local needs (DoH 1989b).

Evidence of effectiveness, such as achieved patient outcomes, would determine what and where commissioners would purchase services but some writers pointed

out that decision-making may not rest on 'quality' of service but rather what was most cost effective (Nicklin and Lankshear 1990, Booth 1992). Such a change had major implications for nursing services, although Bradshaw (1995 pp976) notes that the 'impact of NHS reforms on the working lives of nurses is under-researched'. One further criticism relevant to this review is that 'Working for Patients' (DoH 1989a) and the 'Caring for People: Community Care in the Next Decade and Beyond' (DoH 1989b) was that there was no reference to nurse training. Furthermore, the English National Board (ENB 1989) expressed strong concerns that such business–like NHS schemes were problematic not only for nurse training, but also for the teachers who delivered such developments.

2.6.3. The impact of legislation on nursing education in 1989

During 1989, the Department of Health also commissioned the management consultants Peat Marwick McLintock (DoH 1989c) to review institutional arrangements for the training and registration of qualified nurses, midwives and health visitors. Whilst the recommendations on the constitution and role of the UKCC were well received the funding and management of nurse education and training were more controversial (Buttigieg 1990). Essentially, the Peat Marwick McLintock report (DoH 1989c) advocated the setting up of one national body to manage, fund and accredit nurse training whilst the colleges of nursing would work at a regional level and were 'controlled' by a network of regional officers. Buttigieg (1990) noted that the report reflected a strong interest within nursing to prevent control from regional and local service needs that may be in conflict with the

distinct professional nursing needs. On reflection, Peat Marwick McLintock (DoH 1989c) report was not adopted by the government as it cut across the regional approach envisaged in 'Education and Training' Working Paper 10 (DoH 1989d), which is discussed in the next section.

2.6.4. Working Paper 10 (DoH 1989d)

Working Paper 10 (DoH 1989d) was the product of a working group of the NHS, whereby training and personnel managers identified themselves as representing the 'employers'. A large proportion of the Working Paper 10 (DoH 1989d) document is concerned with commissioning and funding mechanisms for 'non-medical training', which included nursing. However, the origin of the document appears in part to be parallel with other NHS documents namely those that advocated a new cost/pricing market in which health care 'providers' were encouraged to compete on cost and quality of care (DoH 1989a). In professional nurse training the situation was problematic because the direct employers could not be left to decide issues such as student group size or course development. As part of Working Paper 10 (DoH 1989d) consortia of units and trusts were formed within the Regional Health Authority (RHA) to inform planning and training management (Booth 1992).

As indicated, the publication of Working Paper 10 (DoH 1989d) followed the White Paper 'Working for Patients' (DoH 1989a), which stated that the Regional Health Authorities (RHAs) instead of the ENB would fund pre-registration and later post-registration nursing courses. This is a vital point in the context of this review

as this document was to change funding arrangements of nurse education. In this new model, RHAs would be responsible for all training costs, including all courses, student support and clinical placements. Thus, RHAs would, in the light of their manpower demand assessment, fund Project 2000 student nurses within a bursary arrangement. In deciding the number of student places to be provided the paper advocated a staged model and although it was suggested that the stages may not follow a logical sequence, any planning would require careful detail about each of the elements outlined:-

- Deciding the number of student places or quantum of training provided. This activity involved :-

  Forecasting the level of health care to be supplied

  Determining the number and type of staff required

  Deciding where the staff will come from (Manpower planning)

  Determining the number of student or trainee places

  Designing or changing, training capacity to match demand

- providing the necessary funding. The elements of this being:-

  course costs

  student support

  clinical placements

- designing training courses and specifying outcomes
- supplying training and
- monitoring the quality of training and its outcomes

(Working Paper 10 DoH 1989d pp7-8)

In Working Paper 10, there also appeared a strong concern of securing the 'supply' of potential trainees of pre-registration nursing courses in the face of the 'demographic timebomb' (pp 4). It was felt that through a more explicit basis for training arrangements as outlined in Working Paper 10 specific issues of concern would subsequently re- addressed. These included:

- maintenance of vocational and clinical relevance of NHS funded training and the necessary integration of theory and practice during training .
- meet the objective of wider access
- counter the demographic dip of the 1990's
- improve the accountability for public funds and justification of the use
- continue the drive for increased efficiency and effectiveness

(Working Paper 10 DoH 1989d pp34)

Working Paper 10 (DoH 1989d) also appeared to be in keeping with the needs for the new programme of Project 2000 (UKCC 1986) and emphasised the need for closer links between professional education and higher education in the polytechnics and universities (DoH 1989e, Department of Education and Science DoEdSc1989). As a result, a variety of models and partnerships subsequently developed all of which had implications for nurse teachers, students and qualified nurses. In the late 1980's a programme of mergers occurred in which smaller hospital based colleges of nursing were merged to form larger colleges of nursing covering large geographical areas and co-ordinated under direction of a senior management board (DoH 1989e).

The colleges remained in the NHS but arguably Working Paper 10 paved the way forward to facilitate such a programme of mergers. It was claimed in Working Paper 10 (pp37) that 'the Government would prefer to see links with higher education evolve on a gradual, but contractual basis'. Therefore, the colleges remained under the umbrella of the NHS but were expected to demonstrate firm collaborative links with HEIs. It was anticipated that for many this would be within the polytechnics although the removal of the binary line in 1992 changed the status of polytechnics to universities removed this distinction (Brew 1995). This will be more fully discussed in Chapter 5 (Section 5.4.3.1).

In summary, Working Paper 10 altered the contractual arrangements of colleges of nursing and had a major impact on the organisation of nurse education. It was against this background of forces that the colleges of nursing operated within the NHS in the 1980's and early 1990's. The scene was set to facilitate the move of nursing education to HEIs.

2.7. Historical Context of Nurse Education: early 1990s – late 1990s

The national working group for Project 2000 made reference to the need for nursing qualifications to have more academic recognition and the development of links with higher education institutions. The UKCC (1986) states:-

'Professional and academic validation should be pursued from the very outset of a process of change in order to achieve recognition of professional qualification' (UKCC 1986, pp59)

As suggested elsewhere, Working Paper 10 (DoH 1989d) emphasised the need for gradual links with higher education to evolve. By 1989, it was felt nursing would fit well into HEIs. However, using key grey literature of memos, Cox (1993 pp1) noted that one university was under 'some pressure' to locate nursing into his institution. Whether evolution or pressure, a process thus began, which involved the transfer of nurses and their educational programmes into mainstream higher education (DoH 1989e). Moreover, the existing links with nursing colleges paved the way for the subsequent mergers or transference of all nursing colleges into an HEI, a process which was to be completed by 1997 (CVCP 1994a, 1994b, 1994c, National Audit Office 2001).

In 1995, Clifford had noted that the framework for working with higher education was by no means consistent as each college of nursing had the freedom to decide which HEI they preferred to link with (Clifford 1995a, 1995b). As differing HEIs offered various levels of academic support an initial picture emerged whereby single colleges of nursing had a number of courses validated by different HEIs. This had implications for the overall merger events that subsequently occurred.

In preparation for the merger into higher education, the colleges of nursing experienced a series of amalgamations with other colleges of nursing in order to strengthen the position of smaller colleges that merged to form larger colleges. This is summarised in the Royal College of Nursing (RCN 1994) newsletter, which

states that in the 1970's, England had around 150 schools of nursing, in the 1980's around 95 and in 1994 this had reduced to 60 colleges of nursing and health care. Consequently, at this time nurse teachers were experiencing much organisational change in new management structures and for the first time redundancies as a result of centralisation of services (Kenrick 1993). This occurred at the same time as the expected delivery of the new Project 2000 course. Clifford (1993a, 1993b) reported that these changes resulted in some colleges of nursing becoming more and more removed from the hospital centres in which they had traditionally worked. Thus, Clifford (1993a, 1993b, 1996a) predicted in several articles that such change also had implications for the role expectations of nurse teachers both in terms of classroom, administration and clinical responsibilities.

After the series of amalgamations of smaller colleges to larger centres, each new college formalised its links with a variety of HEIs. The transfer of the college was orchestrated by each Regional Health Authority (RHA) which asked for universities to tender their bids for that college (CVCP 1994a, 1994b, 1994c). The bids varied from region to region and requirements were set locally at the RHA level. The universities who wished to competitively tender for the individual college of nursing (some of which had existing links with the nursing college), usually were expected to compile and present the strengths of their bid under the auspices of an evaluation committee.

On this basis the decision was made by the RHA. It is interesting to note that during this process little involvement was expected of one specific nursing college in the West Midlands (Anonymous 1994). Therefore, to understand this in greater depth a review of the grey literature in one locality using memos and minutes of meetings revealed some interesting issues. Firstly, it was interesting to find that in the college of nursing all memos referred to the merger as the 'amalgamation', 'integration' and even 'take-over' whereas the university literature frequently referred to this process as the 'transfer of nursing colleges into higher education' (Hitchen 1993, Cox 1993).

Secondly, the grey literature documents highlight that the university was well prepared about all aspects of the envisaged work and laid out the foundations about the future destiny of staff. The college of nursing memos on the other hand largely focused on courses being delivered at that time and the effect that this would have on students. The university had a modularised approach and as many of the courses at the college of nursing were not modular, this was heavily criticised within university memos (Hitchen 1993).

A further issue noted in the minutes from a range of meetings was the ultimate management structure for staff with the higher education institution. Across the U.K. each nursing college had their own management structures with Principals and Heads of Department (Chapter 3). Once the transfer took place, responsibility for staff would fit within the university as with other lecturing staff and previous

management not required. The grey literature highlighted that senior college of nursing staff were anxious that they would not be offered managerial posts in the university (Burnett 1993). At the same time, a staff surplus situation was identified by HEIs (Cox 1993). It was decided that in order to streamline the workforce, voluntary redundancy or early retirements were to be offered whilst other senior nurse teachers might wish to seek alternative careers. The grey literature highlighted that any leaving packages had to 'generous in nature' (Burnett 1993). In this way one document reviewed stated that the 'university management could dictate the terms of the take-over to the surviving staff, avoiding confusion and ensure smooth transition' (Anonymous 1994 pp1). However, as this was the most senior and potentially experienced college staff who were to be offered such packages, the hidden cost of such redundancies in terms of a loss of skill base to the service was not evaluated.

Whilst employee rights of the nurse teachers, such as pensions and pay awards were to be maintained, respective titles appeared to be one of the most contentious issues in the grey literature at the same locality. The bulk of teaching staff in the colleges of nursing were known as 'Nurse Tutors' and asked for the titles of Senior Lecturer once the merger had taken place. It was also found in the grey literature that some of the existing university lecturers in the Faculty of Health were termed Lecturer but had in reality higher academic qualifications than many of the Nurse Tutors. This was an interesting scenario as the existing university lecturers also felt that they had been interviewed for any post awarded, whereas they felt the Nurse Tutors

were being given the senior posts 'on a plate'. Many meetings appeared to take place before an agreement was reached and appeared only to be resolved when all Nurse Tutors and existing Lecturers in Nursing were all given Senior Lecturers posts. Nurse Tutors were not, however, interviewed and so some contentions remained.

2.7.1. Implications for nursing education of the merger into higher education

As far back as 1988, Owen postulated that there were several implications of an integration of nursing into HEIs. Firstly, Owen (1988) noted that nursing courses would be jointly validated by the HEIs and the national nursing boards (e.g. ENB). At the interface of nursing, this development was important as Owen (1988) noted that nursing qualifications would be more widely recognised as 'academic' courses and this could ultimately assist the professional status of nursing. Chandler (1991a) added that the experience of sharing additional extensive resources with other multi-professional groups in the university was also a way of challenging and thus enhancing the scope of nursing. However, although the merger into HEIs offered a means of enhancing the profile of the nursing profession, nursing staff in clinical areas would once again have to adapt to a new organisation. Indeed, during the amalgamations into larger new colleges, many district areas were involved, so it was suggested that links with NHS clinical areas could be subsequently affected. Luker et al (1993, 1996) therefore warned that this was a difficult path to embark upon when nurses were experiencing serious retention, recruitment and low staff

morale problems and that they already felt many nurse teachers 'had let them down' with respect to supporting staff and students during these amalgamations.

Furthermore, McMillan & Dwyer (1989) studied similar nurse education mergers during the late 1980's in Australia and found that the transfer from hospital training to higher education was a complex and difficult experience for the majority of nurse teachers. They suggested that one antecedent to the Australian nurse teachers' reactions was educational change experienced before the mergers took place. Barton (1998) suggested that in the U.K. this was a similar experience, as many nurse teachers had already experienced substantial change during the amalgamation process of merging from a smaller college to a larger, single organisation. He noted that that when the final decision was made about the choice of university, some staff subsequently retreated in horror even before the merger had taken place!

Chandler (1991a) noted that nurse education would bring to the HEIs additional research development and would offer nursing a much needed publication base. Draper (1996) argued that this was not the case suggesting that research and publication activity were not 'traditional' role attributes of nurse teachers working in colleges of nursing in the NHS, so this could prove to be very challenging for them. These are interesting suppositions given that the grey literature used for this review made no reference to research activity in the negotiated contracts at one university in the West Midlands (Cox 1993).

2.8. Context of Nurse Education: late 1990s to present

The organisation of current nurse education delivery is inherently political. Inevitably, it is nurse teachers who respond and deliver educational nursing programmes, so a review of some of the more recent NHS and DoH publications is necessary. Whilst a centrally funded NHS currently exists the advent of consumerism as reflected initially in The Patients Charter (DoH 1991) arguably paved the way for this movement. In 1993, The Heathrow Debate (DoH 1993) presented a vision of health care by the year 2010, which envisaged the majority of care being delivered locally through a growing range of primary health care initiatives and that patients would have more say about the quality of services and care received. Such documents have resulted in NHS patients and other service users becoming more aware of their rights, and as a result, more evaluative when receiving services offered to them. Thus, Ham (1999) noted that this has meant patients expect value for money, but whilst government funding has risen, consumer demand far outweighs this (DoH 1998a, DoH 1998b).

Other trends are also set to continue. Firstly, one demographic trend is the growing number of elderly people who will place ever-increasing demands on the NHS in terms of care required (DoH 1998b, DoH 1998c). A further demand is that poverty and deprivation, which have long been associated with ill health, remain realities in the U.K. (Ham 1999). At the same time, technological and genetic advances have rapidly developed. Public expectation has also risen with respect to the information about the range of services and it is envisaged that this will continue to do so (DoH

1998a, DoH 1998b, DoH 2000a). Therefore, efficiency of services along with maximum patient user involvement in planning and delivery of those health services is crucial. The environment where care is given has also rapidly changed as there is also an increasing amount of care delivered outside of hospitals, in community or primary care settings and that individuals are expected to take more responsibility for their own health care delivery (Calman 1998, DoH 2001a).

Rushforth and Ireland (1997) noted that such change impacted on health care professionals who have had to reassess and re-evaluate how they currently work together on aspects such as decision-making, budgetary control and rationalization of manpower and physical resources. This has also meant that the planners and purchasers of the NHS and Social Services have had to re-consider how to deliver and monitor the most effective quality care and consequently, demands upon health care staff are greater than ever before (DoH 1998c, DoH 1999a, DoH 1999b, D0H 2000a). This is indeed massive reform based on ambitious NHS plans. However, whilst on one hand such massive reforms are needed to modernise NHS services, on the other hand the target driven culture 'is defying the planners and perplexing the managers who struggle to provide services to patients' (Bradshaw 2002 p1).

There is another urgent issue here to note. The NHS in the U.K. employs over 300,000 whole time equivalent nurses, 22,000 midwives and 10,000 health visitors, and is by far the largest group of NHS employees, but at the same time the NHS, is experiencing an urgent staffing crisis of nurses (DoH 2001a). Indeed, the DoH

(2000b) noted that 20,000 more nurses are required by the year 2004. Thus, a positive recruitment and retention campaign for nurses, midwives and health visitors is currently being implemented to interest school leavers in nursing and encourage those with existing qualifications to return (DoH 1999a, DoH 2000a). Whilst an extra £140 million will be invested in the NHS by 2003/2004 achieving this goal will be a difficult challenge (DoH 2000b). Some of the reasons for this were identified by the RCN in 1999, who commissioned the Institute for Employment Studies (IES) to undertake a survey of 6,000 registered nurses in the U.K. They found that overall nurses felt they were poorly paid, that they experienced considerable work pressure and stress, and that turnover of staff was high (RCN 1999). Whilst these findings had implications for careers advisors and NHS employers, it was clear that any future recruitment and retention would require strengthening of education and training and that nursing education programmes needed to be more flexible (DoH 2000a, DoH 2000b).

Such influences were initially responded to in 1999, in the government's strategy for nursing, known as the 'Making a Difference' (MAD) document (DoH 1999b). This document focused on key areas of nursing such as recruitment, strengthening education and training, developing a modular career framework, improving working lives, improving self-regulation, improving leadership and enhancing quality of care. This document called for radical change to the nursing curriculum and gathered further pace with the publication of the UKCC two year comprehensive review (known as 'The Peach Report') (UKCC 1999). This review had sought to

evaluate the effectiveness of whether U.K. pre-registration student nurses, midwives and health visitors were 'fit for practice, purpose and award' (UKCC 1999 pp34). This was to be an important review for nurses, midwifes and health visitors, as it was the first analysis of pre-registration nursing and midwifery education since Project 2000 (UKCC 1986). As the UKCC (1999) document recommended key change to pre-registration delivery it is pertinent to review it further.

2.8.1. Analysis of The Peach Report (UKCC 1999)

The commission chaired by Sir Leonard Peach (formerly Chief Executive of the National Health Service Management Board) was given 12 months to:

> *' prepare a way forward for pre-registration nursing and midwifery education that enables fitness for practice based on health care need'.*
>
> (UKCC 1999 pp6)

In undertaking the above brief, the commission used an extensive range of evaluation strategies including a survey of targeted final year students and newly qualified staff nurses from diploma and degree nursing and midwifery courses. They also reviewed nursing and midwifery attrition rates in the U.K, ascertained the views from a panel of invited experts and analysed relevant literature such as Healthcare Futures 2010 (Warner et al 1998), which sought to outline contemporary thinking about the future of health care in the millennium.

Initially, 16 pilot sites commenced the new nursing curricula based on UKCC (1999) report with all other sites across the U.K. thereafter. The aspects outlined in UKCC (1999) report provide a framework for discussion in this review:-

- Increasing Flexibility
- Achieving Fitness for Practice
- Working in Partnership

2.8.1.1. Increasing Flexibility

The UKCC (1999) document clearly states that future nurses will need new knowledge, new skills and new working practices if they are to meet these demands. The first recommendation was to improve the acceptance of wider utilisation of Access and National Vocational Qualification (NVQs) to enter into nursing whilst also develop further the cadet schemes. The schemes involve the progressive development of health related NVQs (and placements) from age 16 upwards with direct entry to pre-registration nursing thereafter (Matthew 1998).

On entry to pre-registration nursing the UKCC (1999) report recommended that the Common Foundation Programme (CFP) be reduced from eighteen months as outlined to one year, after which students would enter a branch programme for two years. Given the previous critical literature about Project 2000 (Elkan and Robinson 1994, Norman et al 1996) the CFP would also be focused more in the context of all four branches and placements and skills would be introduced at an early stage in the programme. In order to increase the flexibility further after the first year students

would be also able to step off and be given academic and practice credit if they chose to leave the pre-registration nursing programmes. However, whilst these initiatives would seem to increase flexibility, in the long term how they improve recruitment and retention and develop new, life-long skills of nurses is still under-researched and so is not fully known.

2.8.1.2. Achieving Fitness for Practice

As outlined, previous literature about Project 2000 had indicated that students were ill equipped in practical skills upon qualification. It was therefore important that the UKCC (1999) report attempted to readdress this situation. A fundamental principle of the UKCC (1999) document was that on qualification nursing students would be 'fit for purpose'. This phrase was widely adopted to describe a practitioner who had the knowledge, skills and attitudes to function as an autonomous practitioner within the present health care system.

Stakeholders of nursing education, however, all had their own understanding of this phrase, which can be summarised thus;

1. *Fitness for Practice* – this concept relates to concern about how to assess competence to practice; how this evolves over time and whether a student is safe to register as a practitioner. The UKCC (1999) outlined this as the primary objective suggesting that any pre-registration nurse education programme should be based on outcome-based competencies such as expected 'core' and specific branch skills,

transferable and life long skills. However, this is an unknown assumption as Chapman (1999) found that in an outcome-based competency programme in Australia that some outcomes became so rigid that they subsequently limited overall development of the nursing students. In short, the outcomes were only as good as those individuals who planned and implemented them.

2. *Fitness for Purpose* – Within the UKCC (1999) document was a strong concern that a newly qualified nurse should be able to function competently, a view advocated by the service contractors. However, the ENB (1999) noted that this was in conflict with the educational principles of the ENB and UKCC, and felt that it was unreasonable for universities to base their courses on this type of learning. Moreover, although the UKCC (1999) report advocated stronger links and partnership to the service contractors (who control contracting of nursing courses), there could potentially be a dichotomy of interests. Thus, it will be of interest to observe how the universities do indeed appease any conflicting issues that might arise.

3. *Fitness for Award* – Arguably, this has always been the concern of HEIs, often discussions focusing on whether a student attained the level and depth for a Diploma or Degree. The UKCC (1999) suggested that in order to achieve the fitness for award, all student nurses should be assessed equally by lecturers and practitioners, in academic and clinical settings. Whilst this would seem a positive strategy towards the spirit of partnership advocated in UKCC (1999), LeVar (1996)

had noted that in this approach fitness for award can be compromised as the focus becomes skill-based, which may or may not allow for creativity and academic synthesis required by higher education.

2.8.1.3. Working in Partnership

Finally, the UKCC (1999) report advocates that a strong collaborative partnership should be fostered between the HEIs (the providers) and the educational consortia (the purchasers). The concept of partnership has been a key issue to emerge from current government policy and the UKCC (1999) document, following on from the 'Making a Difference' (DoH 1999b) paper, offered guidance on this at every possible level. The UKCC endorsed the work of Hughes (1998) who had found that collaborations between HEIs were overly competitive and that improved communication was needed in order to balance increasing student numbers with shortages of placements, specifically in the areas of child health, maternity and community. The UKCC (1999) report, therefore, strongly advocated that joint planning and strong partnerships must occur between NHS and HEIs to develop and implement programmes.

The need for partnerships were also demonstrated in the briefing notes of the Committee of Vice Chancellors and Principals (CVCP) (2000), some points of which included:

- The HE sector provides virtually all the pre-registration education for the U.K. This includes doctors, nurses, midwives and other allied health professionals
- Over 70 universities in the UK offer degree and diploma programmes in nursing and that nursing is the biggest group accessing HE during the academic year of 1997/8 (Full time 53,198 and part-time 44,245).

Undoubtedly, the merger of nurse education into HEIs has implications for the purchaser-provider delivery model, as it is the educational consortia who carry an obligation to monitor the effectiveness of education provision in health care. Thus, purchasers were made responsible for finding adequate quality placements for the students commissioned, whilst it was recommended that HEIs ensured that a diverse group of lecturers were developed to ensure that students had access to specialists in practice, skill-based work, management, assessment and research. In this way the UKCC (1999) envisaged that good partnerships would be fostered at all levels in order to take the NHS plans forward, a point which has been repeatedly reiterated in a plethora of the most recent documents (DoH 2000b, DoH 2000c, DoH 2001a).

2.8.2. The interface of current health policy with nurse education

Having analysed the ethos and some issues that underpin the current DoH directives and the UKCC (1999) document it is relevant to this review to relate such issues to the role of the lecturer of nursing working in HEIs. Whilst previous evidence was utilised in the UKCC (1999) report to highlight that the nurse teacher's role was problematic, it noted that, in the clinical settings this hardly ever went beyond negotiation of placements, conducting educational audits, providing pastoral care and academic support to students and ward staff (Gilmore 1998, Day et al 1998). The UKCC (1999) document also noted that evidence after the merger of colleges of nursing into higher education was limited and largely anecdotal. It was thus recommended that lecturers evolve into specialists of management, teaching, practice or research and that a student should have access to this range (UKCC 1999). Moreover, in 2000, the UKCC added that if lecturers of nursing wished to develop their practice skills, funding should be made available for them to spend time in the clinical field undertaking activities to either enhance their own development or the development of qualified nurses mentoring and assessing skills (UKCC 2000). Linked to this, the ENB (2001) published their guidelines for the preparation of mentors and teachers.

Arguably, whilst there is a deluge of DoH policy documents, many of the most recent make little reference to the issues related to nurse teachers. Instead, they tend to focus on continuing professional development (CPD); the concept of lifelong learning and the need to foster strong partnerships as the core educational issues of

the NHS workforce (DoH 2000a, DoH 2001a). Furthermore, the most recent NHS Plan document (DoH 2000b) makes specific references to collaborative working across professional groups including shared learning but offers no clear strategy for educators.

At the same time other significant developments in health care delivery also affect nurse teachers. Currently, the key agency for carrying the responsibility for monitoring quality in HEIs is the Quality Assurance Agency (QAA). Since 1998, a new mechanism for monitoring the quality of nurse education provision has been implemented, in addition to the ENB annual review that had previously been the norm. Whilst this is more fully discussed in Chapter 5 (Section 5.4.3.2), it is relevant to note here that, during the academic years of 1998-2000, the QAA undertook a comprehensive review in collaboration with the ENB of all health care education (ENB 1998, QAA 2001). The subsequent report of the total provision of nurse education in the HE sector was rated overall as very positive, with specific positive areas being widening access, good working relationships with the service sector and flexibility. On the other hand, less favourable issues noted were the increasing problems of appropriate clinical placements for an increasing body of student numbers, inadequate learning resources including accommodation and evidence of multi-professional sharing (QAA 2001). Inevitably such findings have implications for those professionals involved in delivery of nursing education.

Other developments still to be fully realised are the replacement of the ENB with the Nursing and Midwifery Council (DoH 2001b), the introduction of the new Health Professional Council (DoH 2001c) and changes in the Quality Assurance Agency (QAA), which will include a 'combined' approach to the assessment of health care professional courses (QAA 2001). There are clearly many implications here for nurse teachers. What is worrying is that, in 1998, the ENB reported that whilst student numbers were rapidly rising, less recruitment of nurse teachers was occurring and retention policies in HEIs were not being fully developed compared with the model developed in the NHS (UKCC 1998, Day et al 1998, ENB 1998). In addition, Clifford et al (2001) noted that redundancies of nurse teachers were high prior to and at the merger into higher education, using the ENB documents to highlight that there were 6161 nurse teachers in 1996; 5095 in 1997 and 4851 in 1998 (ENB 1996b, ENB 1997, ENB 1998a). Unfortunately, Clifford et al (2001) added that since 1998 the ENB has ceased to compile current nurse lecturers in post, as this is currently collated by local educational consortia, so actual numbers of nurse teachers are unclear. Coad and Devitt (2000) noted therefore that the 1998 ENB portrayal (Day et al 1998, ENB 1998) may not have changed as indeed student numbers continue to rise whilst there has remains limited recruitment and retention strategies in HEIs of nurse teachers.

The consequences of this are that there are less nurse teachers available whilst student nurse group sizes continue to rise. Implementing the UKCC (1999) report whilst developing clearer role models could, therefore, be very problematic for nurse teachers. This may add to increased responsibilities and potential stress of nurse teachers, but currently information about the impact of such issues on the nurse teacher role is currently limited. Furthermore, given that the role of the nurse teacher has been highlighted as a 'Jack of all Trades' (Nolan 1987, Clifford 1995a, Luker et al 1993; Carlisle 1996, 1997) before the merger into higher education, the challenges faced by nurse teachers may be even greater than before.

2.9. Summary

This chapter has served to outline the many reports and influences which have precipitated the current changes related to nurse education. From the review to date, it would seem that the background of nursing is not only complex but the intricacies of a service-led nurse education have dominated many developments and initiatives. Professionalisation of nursing is undoubtedly slow, and has left behind a legacy of confusion, but nether the less change has occurred.

The literature reviewed has also highlighted that demands on nurse teachers are at all levels. For example, the demands made by scientific and technological advances, changing patterns of disease and illness, public expectations and government restraints have presented nursing education with many challenges. This must have implications on the role of nurse teachers who are expected to deliver the programmes in HEIs. It is thus imperative that the nurse teacher role is fully understood. In the following chapter, therefore, the evolution of the nurse teacher role is specifically explored.

Chapter 3

The development of the role of 'nurse teacher'

3.1. Introduction

To date this review has outlined the historical context of nursing and explored some of the antecedents related to the merger of nursing colleges within the NHS into HEIs. The literature served to indicate that in the midst of these upheavals were the nurse teachers who had to respond to any changes in order to deliver nursing educational programmes. This must inevitably have had considerable impact on the nurse teacher role as they moved from colleges of nursing within the NHS to HEIs.

Role theory has been extensively well documented and in defining the literature for this review a decision was made to largely use literature pertaining to the nurse teacher role. However, whilst a number of research studies in nursing education have drawn upon the concept of role theory, this was largely implicit and indeed only the work of Clifford (1996b), undertook an in-depth analysis of the nurse teacher role using Biddle and Thomas (1966) framework. Therefore, although this chapter will explore the role of the nurse teacher it will begin with a contextual overview about role theory to set the scene.

3.2. Evolution of the meaning of 'role'

The origins of the term 'role' derives from the French word, *rotula*, which penetrated English and European language to mean little wheel and later scroll of paper usually associated with legal or political arenas (Moreno 1962 pp80). In Ancient Rome and Greece scrolls of paper were called 'rolls' from which actors read their parts by the prompters. Hence the actor played his character or role to the audience and the concept of actor thus emerged (Biddle & Thomas 1966). These may be interesting anecdotes but the origins of role pertaining to a person's technical work can be identified in several key writings tracing back to the 1930's although three significant writers stand out notably, those being Mead (1934), Linton (1936) and Moreno (1962).

Mead (1934), a social philosopher, was most interested in problems of interaction and how humans adapted to change in order to find a 'social niche'. From this work he explored the concept of role as social behaviour and developed the notion of role-taking where a person anticipates or interprets another person's role thus utilising it themselves (Turner 1968). Although significant in the origins of symbolic interactionism in sociology, a further role influence is evidenced in the work of Moreno (1962).

Moreno (1962), a psychiatrist developed the use of 'role playing' known as the dramaturgial perspective, which Moreno specifically pioneered in psychodrama in the search to explore behaviour and as an attempt to reintegrate disturbed patients.

Moreno (1962) argued that in role playing, a process occurs where there is firstly a stage of role perception (awareness of role) followed by role enactment (role performed). Linton's (1936) work was also influential in that as an eminent anthropologist he believed that there was a close relationship between role and position in society or status. Thus, Linton (1936) isolated and analysed concepts related to the individual's role and their subsequent social structures such as position in a given society. According to Biddle & Thomas (1966 pp7) such writers 'did much to establish role – both as a term and concept' and were consequently joined by others such as Cottrell 1933, Parsons 1937, Newcomb 1942 and Sarbin 1943 (cited in Biddle & Thomas 1966).

It is from these origins that Biddle & Thomas (1966) in their comprehensive analysis of role demonstrate the complexity of this concept. Within their work they purport that a simplistic analysis of role includes three categories (Appendix 1). The first category is that the role encompasses all those concepts used to apply to the individuals such as self, every person and group. With respect to the second category concepts relating to behaviour reflect the role performed. Arguably, this would change from time to time and place to place depending on factors such as the organisation, responsibilities, culture and the persons who they interact with. A third category also exists which overlaps both a person's title and their expected role behaviour (Biddle & Thomas 1966). However, Biddle and Thomas (1966) note that a person's title and their expected role behaviour may not be congruent resulting in perceived role conflict.

Such principles can be related to nurse teachers.

3.3. Role theory related to nurse teachers

Much of literature in nursing education appeared to implicitly support the notion of Biddle & Thomas (1966) three categories but appear to use the term 'role' quite liberally (Buttigieg 1990; Cave 1994; Davis 1991; Crotty 1993; Love 1996 and MacNeil 1997). Jones (1985), Stephenson (1984) and Sheahan (1981) all explored the role of nurse teachers but all emphasised how others viewed the nurse teacher. Only the work by Clifford (1996b) was found to have attempted a critical analysis using the framework of Biddle & Thomas (1966). In the analysis by Clifford (1996b) it was found that the role of the nurse teachers evolved through a multitude of expected attributes and this in itself contributed to the degree of conflict. This can be explained further using the titles nurse teachers have been given over the last century.

3.3.1. The Nurse Tutor Role

The nurse teacher role did not exist as a formal occupation for many years. Nurse education began at the bedside of the wards under the auspices of the matron and it was the ward sisters who were responsible for the practical instruction and apprenticeship of nurses in training (Martin 1989, Crotty & Butterworth 1992, Clifford 1995a). In addition, the medical staff contributed to the theoretical input (Maggs 1987).

The first evidence of a substantive appointed post as a 'nurse teacher' in the U.K. was Miss Agnes Gullan, employed in 1914 at St. Thomas's Hospital, London. This was a medical initiative where in her post she remained under the authority of the matron but was instructed to provide training in writing skills, the Bible and to supervise the probationers attendance to the doctors' lectures. Given the imbalance of power-relationship with nurses and doctors at this time she received no formal training or qualifications and was largely subordinate to the doctors (Davies 1980).

The strong association between the clinical and teaching role emerged in the title of 'Sister Tutor'. During the 1920's and early 1930's courses for preparation of Sister Tutor instruction gradually developed, the successful candidates being awarded internal hospital certificates (Bendall & Raybould 1968). In 1926, formal preparation courses commenced when the University of London offered a full time diploma in nursing for those nurses wishing to pursue a teaching career. This course included instruction on how to teach as well as professional nursing knowledge base of what to teach in the form of life sciences, mainly based on a largely medical model of illness and physical symptoms (Buttigieg 1990). This was seen as a useful programme but was not felt to cover a breadth of sufficient teaching methods and material so in 1952 it was extended to two years and subsequently ran until 1983.

As noted in Chapter 2 (Section 2.4), in 1919, the responsibility of appraising all nursing courses came under the jurisdiction of the General Nursing Council (GNC). As a result of an identified shortage of nurse teachers in 1954 the GNC first published a report that stressed that a Sister Tutor was the best person to support a student nurse to qualify (GNC 1975). The GNC suggested that this role should be developed with input from general education and nursing education though no information is given as to how this might be performed. Later, in 1965 the qualification of Registered Nurse Tutor (RNT) emerged as a recognised qualification approved by the GNC to replace the title of Sister Tutor (GNC 1975).

The RNT programme was a one year technical teachers certificate preparing nurses for a teaching role in the classroom and clinical areas whilst also providing insight into curriculum development (Martin 1989). The programmes brought other new developments for example nurses studied for the first time alongside people from other occupational groups. The guidelines for entrance to the programmes were set by the GNC, so to qualify for entrance a prospective candidate had to demonstrate considerable nursing experience at a senior level (at least three years as practising nurse) usually at the level of 'Sister in Charge' (or equivalent) and have evidence of support from senior nurses.

The Salmon Report published by the Ministry of Health (MoH, 1966) was to have some impact on the role of the nurse tutor. This report aimed to re-define nursing roles and instigate positive changes in relation to communication pathways

designed to improve patient care. But it also highlighted that there was great dissatisfaction felt by nurse tutors in their role and linked these to three specific areas:

1. The subordination of 'nurse tutors' to nurse administrators (many of which were less well qualified than teaching staff)

2. A lack of acceptance of the 'nurse tutor' as the person responsible for education of the student nurse.

3. Incomplete control of their own departments

Whilst the Salmon Report (MoH 1966) went some way to recommend improvements for 'nurse tutors' it acknowledged that a 'Senior Nurse Tutor' role should have time given for school activities and clinical teaching. However this report did not offer a specific outline of the expected role. For example, whether the location of the role should be either entirely in the schools of nursing or in the clinical area was not addressed.

Subsequently, The Briggs Report (DHSS 1972) outlined previously, (Chapter 2; Section 2.4) recommended radical change to the nurse tutor role. It suggested that nurse tutors should be less general teachers and that they should be a person who should have a specialist clinical interest such as in surgical or medical nursing not 'a maid of all work required to teach all subjects in the nursing syllabus'. Thus the 'Clinical Teacher' emerged.

3.3.2. The Clinical Teacher

From the 1970's until the late 1980's it was possible to train as a 'Registered Clinical Nurse Teacher' (RCNT) within the UK, the purpose being to teach in the clinical areas (DHSS 1972; Martin 1989; Crotty and Butterworth 1992 and Clifford 1993a). The role was distinct from the RNT in that the preparation for this role involved a City and Guilds training course either full time for six months or through day release schemes in a polytechnic or other institute of higher education. The course was geared specifically to those wishing to teach student nurses in the clinical areas, and indeed many were often working in the posts before entry to the RCNT course being frequently referred to as an 'Unqualified Clinical Nurse Teacher'. In contrast, the RNT course was seen as equating with a teaching qualification at either certificate in education, diploma in education or degree in education level (Clifford 1993a).

However, the clinical teacher role was severely criticised, as they were often abused in that they were expected to undertake classroom roles rather than using their practical skills (Nolan 1987). There was also much confusion about the title of 'Clinical Teacher' as opposed to what was considered the more credible Nurse Teacher or Tutor (Buttigieg 1990). Thus, it was not uncommon for those nurses working as a Clinical Nurse Teacher to decide to move on to other teacher preparation programmes (Nolan 1987). As a consequence there was strong call from the professional nursing bodies to abolish the RCNT course so in the late 1980's this course ceased to run (Martin 1989).

3.3.3. The Registered Nurse Tutor

With the abolition of the RCNT qualification there was only one route into nurse teaching as a career, this was the Registered Nurse Tutor (RNT) course. Following a review by the ENB (1985), it was suggested that this individual would teach both in the classroom and the clinical settings and whilst they were in clinical areas should carry clinical responsibilities. Furthermore, the role was viewed as the full teacher role in which the nurse teacher was responsible for the overall education programme including a role in the classroom, curriculum development, student support and clinical teaching (Clifford 1993a; 1995a; 1995b).

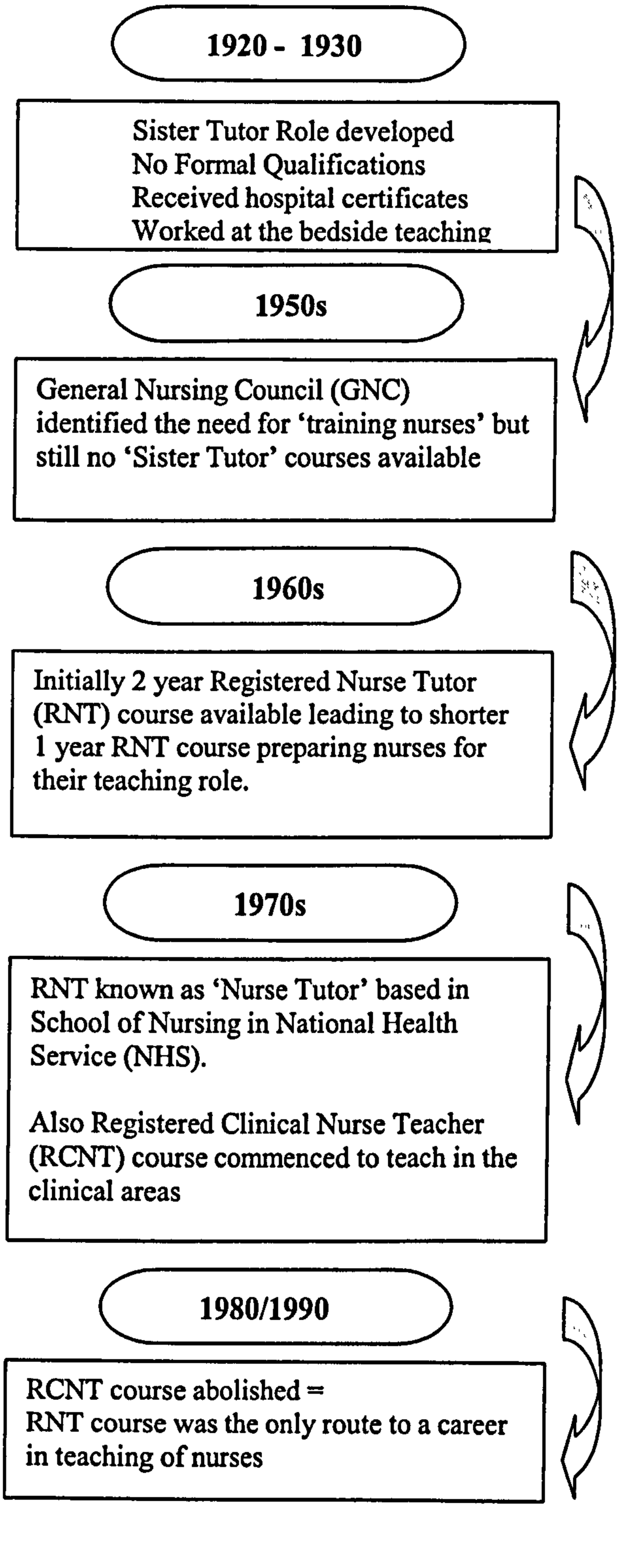
The academic qualification associated with these courses was variable but many were set at post-graduate certificate level and individuals thus received a certificate in education award. In 1989, the Department of Health (DoH 1989d) and the ENB (1989) recommended that all nurses emerging from approved teacher training programmes would be graduates by 1995. As a result, several universities modified their courses to a degree level enabling individuals to qualify with a first degree and an approved teaching qualification. The ENB funded several initiatives to support this change and approved the centres that offered these programmes (ENB 1990). However, criticism was made that whilst the programmes specified that nurse teachers should have supervised teaching time there was a lack of reference made to the actual clinical role expectations (Stoker and Hogg 1992, Clifford 1995a, 1995b). Other part and full time degree options were also available to nurse teachers who had their certificate or Diploma in Education but were not graduates.

Such programmes still continue, supported by the requirements of the most current ENB documents (ENB 2001). Choice of programmes tend to be wide, flexible, run on a day release or modular basis and are supported by the employing institution.

It is worth noting that several studies clearly demonstrated that many of these teacher preparation courses have left nurse teachers feeling inadequate to undertake the role (Buttigieg 1990; Crotty 1993; Clifford 1995a and ENB 1998b). Consequently, suggestions were made about changing the pattern of nurse teacher preparation programmes (UKCC 1999). Buttigieg's (1990) study concluded that nurse teachers should have the opportunity to undertake teaching courses whilst retaining a clinical role, a suggestion which continues to emerge in even the most recent literature (UKCC 1999).

Figure 3.1 outlines in brief some of the previously mentioned points, mapping the historical development from the 1920's to 1990 of the nurse teacher role, whilst discussion pertaining to the role after 1990 will be explored later in this chapter. Figure 3.1 also serves to highlight that the nurse teacher role has not been static, but one that has considerably changed. Arguably, it is this rapid change that has served to add to the confusion about the expected characteristics and overall activities of nurse teacher role. It is therefore pertinent in the next section to explore these issues further.

Figure 3.1. The historical development of the nurse teacher role (1920's – 1990)



3.4. Overall characteristics and activities of the nurse teacher role

In reviewing the contextual literature the question arises why do a number of nurses choose to enter nurse education as a career and what is expected once they do. Traditionally, the lead nursing positions known as the 'Head of Nursing', 'Matron', 'Director of Nursing' and/or 'Director of Nurse Education' were very influential in the process of practice development and suggested potential senior nurses entered education as result of being advised to (Martin 1989, Clifford 1995a). A dearth of literature was found pertaining to the expected role and associated educational change. Therefore literature is presented here in three parts; before 1990, after 1990 before the merger into higher education and after the 1990s following the merger into higher education when changes to the organisation were being implemented.

3.4.1. Studies of Nurse Teachers before 1990

For several decades there has been concern regarding the role of the nurse teacher and several studies from the 1970's explored the different expectations of the role including classroom, clinical, personal and professional development and administration duties. Key studies are summarised in Table 3.1, but are analysed in the context of the study reported here.

Table 3.1. Published research relating to nurse teacher role before 1990

Author/date	Study details	Sample (n =)	Key issues identified
Sims (1976)	Questionnaire survey **Focus – to define nurse teacher characteristic and opinions on satisfaction of role**	4671 nurse tutors (72%) and clinical teachers (28%) (69% response rate = 2923 completed questionnaires) 74% female/ 49% married	73% satisfied with role (females preferred contact with patients and males administration duties) with 22% dissatisfied (conflict between service and education needs, work pressures and inadequate definition of responsibilities)
House & Sims (1976)	Questionnaire survey **Focus – satisfaction of jobs and role**	2923 completed as above (956 subjected to further analysis)	Results indicated a common decline in role status and perceived lack of power in education.
Crawshaw (1977)	Postal questionnaire with Registered Nurse Teachers (RNT) **Focus – how much time nurse teachers spent with students in clinical areas**	85 nurse teachers in 8 schools of nursing (48 nurses responded)	25% of nurse teachers spent no time in clinical practice, 34% spent 1-2 hours per week, 23% spent 3-4 hours per week and only 2 spent more than 8 hours per week.
Sheahan (1981)	Questionnaire survey **Focus – to explore tutor / student relationships**	317 student nurses and 93 teaching staff (17 senior tutors, 41 RNT's and 35 clinical teachers)	Role attributes of nurse teachers were unclear – students and teachers had different ideas of role
Stephenson (1984)	Grounded Theory – questionnaire survey **Focus – to explore 'ideal versus real' nurse teacher role**	22 students and 23 nurse tutors (10 senior tutors)	'Ideal' teacher was seen as friendly, approachable, good at professional relationships and competent in teaching and clinical work. Conflicts between school of nursing and wards were identified

Author/date	Study details	Sample (n =)	Key issues identified
Jones (1985)	Attitudinal Scales **Focus – restraints of nurse teacher role in clinical areas**	24 nurse teachers (16 clinical nurse teachers and 8 senior tutors)	'Visits' by nurse teachers rarely meant clinical teaching rather reviewing student progress or 'trouble-shooting'. Nurse teachers expressed 'stress' at having to perform or teach practical skills
Nolan (1987)	Survey using checklist from interviews and diaries **Focus – categorise performance of tasks performed by grade in teaching role**	200 nurse teachers (RNT) 59 clinical teachers 44 senior teachers (n = 303) in 38 schools of nursing	Analysed the range of activities nurse teachers undertook – largely tasks were clinically based.

As far back as 1976, a study undertaken by Sims identified general characteristics of the nurse teacher role and their opinions of satisfaction versus dissatisfaction. From the 2923 questionnaires completed, 73% were satisfied with role and 22% were not. Interestingly, the 'satisfied' group of female nurse teachers preferred contact with patients whilst the males nurse teachers preferred administration duties. Conversely, the reasons for dissatisfaction included conflicts between service and education needs, staff shortages, work pressures and inadequate definition of responsibilities.

From the 2923 completed questionnaires of Sims (1976) study, further analysis of 956 was undertaken by House and Sims (1976). This indicated that nurse teachers also felt that there was a decline in their role status and lack of overall influence in the education process. However, some of the findings of House and Sims (1976)

report appear very subjective and generalised. Despite such issues and although over 20 years ago, both reports provided comprehensive data about the levels of satisfaction/ dissatisfaction of the nurse teacher role attributes.

A small study undertaken by Crawshaw (1977) explored how much time nurse teachers spent with students in clinical areas known as 'clinical visits'. Of the 48 nurse teachers who responded it emerged that 25% of nurse teachers spent no time in clinical practice, 34% spent 1-2 hours per week, 23% spent 3-4 hours per week and only 2 spent more than 8 hours per week. Interestingly, 56% of the respondents would have liked to spend more time in clinical supervision but could not due to other cited responsibilities such as classroom teaching (12 hours per week), preparation for class (9 hours per week), meetings (2-5 hours per week) and 'counselling' (4 hours per week).

Much of the literature about nurse teacher at this time appeared descriptive, but one piece of work that was particularly useful was Sheahan (1981). Sheahan (1981) explored the perceptions of 317 student nurses and 93 teaching staff (17 senior tutors, 41 RNT's and 35 RCNT's) in one regional health authority. He noted that there were areas which learners and nurse teachers agreed and disagreed on with respect to nurse teacher role. For example areas of agreement included being a positive role model, individualised teaching, providing learner feedback and being 'up to date'. Areas that were not agreed included the nurse teachers role in moral and pastoral care (nurse teachers felt they were able to support but students felt they

needed more than was received); the clinical specialist role (nurse teachers felt they were specialists but students did not) and management of the library (learners felt the nurse teacher should manage resources better). This study is useful in highlighting the conflict in perceptions about the role and balancing the needs of teachers and students. Similarly, Stephenson (1984) used a grounded theory approach with 22 students and 23 nurse tutors (10 of which were senior tutors) and found that the 'ideal' teacher was seen as friendly, approachable, good at professional relationships and competent in teaching and clinical work. However, there was a distinct lack of information about the sampling frame as 50% of the sample were senior tutors and 50% were males (not the 'normal' distribution in nurse education) so it is difficult to generalise results. A further aspect not fully explored by Stephenson (1984) was the clinical role of nurse teachers, an aspect expanded by Jones (1985) study. In Jones's (1985) it was found that visits by nurse teachers to the clinical areas rarely meant clinical teaching, but rather included visiting, largely to undertake student progress reviews or 'trouble-shooting' roles. Jones (1985) also noted that some nurse teachers' felt stressed about teaching clinical skills and had several reasons to justify the lack of clinical input including classroom, teaching demands.

One further key piece of work performed by Nolan in 1987 highlighted actual nurse teacher activities and was felt to be the most useful piece of work from this time for this review. Nolan (1987) surveyed 200 nurse teachers (RNT), 59 clinical teachers (RCNT) and 44 senior teachers (n = 303) in 38 schools of nursing in order to

analyse tasks performed by grade in nurse teacher role. He developed a 454 itemised checklist of tasks and behaviours performed by nurse teachers at different grades and identified 16 groups of nurse teacher activity, which were categorised as follows:

- Group 1: Formalised teaching
- Group 2: Learner appraisal
- Group 3: Basic Training
- Group 4: Learner management
- Group 5: Provision of experience
- Group 6: Management of teaching
- Group 7: Peripheral activities
- Group 8: Examination administration
- Group 9: Information exchange
- Group 10: Dominant teaching
- Group 11: Basic clinical teaching
- Group 12: Trainee teacher supervision
- Group 13: Senior management
- Group 14: Correlation of theory with practice
- Group 15: Resource management
- Group 16: Executive management

Nolan (1987) found that a total average number of hours spent by teachers was 36.9 a week. These were broken down as follows

- Classroom teaching 11.6 hours
- Clinical teaching 5.3 hours
- Counselling 2.8 hours
- Marking and preparation 4.8 hours
- Administration 7.2 hours
- Travel 1.5 hours
- Unspecified 3.7 hours

One interesting aspect of Nolan's (1987) study was the expected clinical role of nurse teachers. According to McCabe (1985) the clinical learning environment is of

vital importance to the student and the clinical role of nurse teachers is essential if the discrepancy between what is taught in the classroom and what is practised in the clinical area is to be reduced. Nolan (1987) highlighted the conflict between nurse teachers trying to fulfil both a classroom/academic role and clinical teaching role and as a consequence a significant of number of nurse teachers did not undertake any clinical work. Indeed, 38.5% made no comment about their clinical teaching role, which is interesting when in comparison 92% commented on their classroom role. Those that did, commented that clinical teaching was largely focussed on in the introductory block, which was when the student nurses first entered nursing programmes. Nolan (1987) also found that a significant amount of time was utilised on administrative tasks that took almost one day per week and included extensive and varied duties such as letters, filing and telephone calls.

In summary, Nolan (1987) was the most useful work reviewed as studies before 1990 were largely descriptive. However, overall the studies strongly indicated that the nurse teacher role has always been complex and that some of the expected duties may not be appropriate use of the nurse teacher's skills and time, thus adding to role conflicts.

3.4.2. Studies related to the role of nurse teachers after 1990 (prior to the merger into higher education)

Literature about the nurse teacher role after 1990 tends to focus on the common expected role attributes and associated role satisfaction. For clarity the studies have been divided into those pertaining to role (Table 3.2. pages 76 - 78) and those into the impact of Project 2000 (Table 3.3. pages 85 - 86). Overall, all the studies presented demonstrate some common role characteristics and attributes. Out of the range of literature reviewed, only those that were specific to the focus of the study reported here have been analysed (Davies et al 1996; Clifford 1992, 1993a, 1995a; 1995b,1996a, 1996b and 1999; McElroy 1997; and Cahill 1997).

Table 3.2.

Published research relating to nurse teacher role after 1990 in the UK

Author/ date	Study details	Sample (n =)	Key issues identified
Buttigieg (1990)	Questionnaire survey **Focus – nurse teacher preparation (ENB funded project)**	n = 298 in total responded. Represented by: 128 Directors of Nurse Education, 5 Directors of Nurse Education & Midwifery, 113 Midwifery teachers, 23 Health Visitor /District Nurse Leaders, 21 course leaders, 2 Occupational Health Leaders and 6 'Other'	Preparation for nurse teachers inadequate and poor career advice. Nurse teachers should have the opportunity to undertake teaching courses whilst retaining a clinical role. Recommended closure of clinical teacher role and work as an 'unqualified' nurse teacher
Jeffree (1991)	Questionnaire survey of nurse teachers, clinical managers and students **Focus – Role of the link nurse teacher**	Unclear number but link teaching wards were used at one acute general hospital in the UK	Lack of time was greatest problem identified by all 3 groups. Working with students was a low priority and unclear role. Clarification of link role needed and 'closer' relationships between clinical staff and teachers

Author/ date	Study details	Sample (n =)	Key issues identified
Clifford (1992, 1993a & 1993b)	Pilot interviews and questionnaire survey of nurse teachers in one nursing college **Focus – role of the nurse teacher**	40	Preparation for role and reasons for entering nurse education. The lack of role clarity of clinical link role such as liaison and support was explored.
Crotty (1993)	Interviews with nurse teacher from 6 nursing colleges **Focus – clinical teaching role (part of a larger project)**	12	Non of interviewees undertook clinical teaching but maintained 'clinical credibility' through update of theoretical knowledge.
Owen (1993)	Action Research **Focus – to explore teaching input in one clinical area**	Unclear number	Nurse teachers impacted very little on clinical environment
Baillie (1994)	Interviews with nurse teachers in one college of nursing responsible for pre-registration education **Focus – Clinical role of nurse teacher**	10	Lack of role clarity as conflicting views as to nurse teacher role in practice. Only 1 nurse teacher participated in clinical practice. Level of dissatisfaction high. Conflicting nature of 'jobs' (time versus lack of value of role)
Clifford (1995a, 1995b, 1996a & 1996b)	Questionnaires with repeated in-depth interviews of nurse teachers in one college of nursing	245 distributed – 126 returned (77 were the bulk of 'Grade 2' teaching	Nurse teachers undertook classroom, management and administration roles. Less undertook research teaching and highlighted difficulty in meeting clinical role
Skelton et al (1995)	A three-phased quantitative and qualitative study using questionnaires, interviews, a learning contract and reflective journal **Focus- the effective performance of clinical link lecturer role**	Phase 1 – 82 qualified nursing staff in nine nursing specialities. Each ward had a clinical lecturer linking Phase 2 – 70 as above Phase 3 – application & implementation of findings	At Phase 1 the role was viewed very positively. Each area interpreted role differently. Quality of nurse teachers link systems and 'visits' were important such as accessibility and not the quantity Recommend improved job contract

Author/ date	Study details	Sample (n =)	Key issues identified
Davies et al (1996)	Survey method	Nurse teachers in one college of nursing	Nurse teachers had a wide range of actual and potential roles but little or no practice teaching.
McElroy (1997)	Focus group method **Focus – development of the nurse teachers role**	10 groups involving 52 nurse teachers (Location unclear)	Themes were generated from key words and phrases. These included clinical links, 'clinical credibility', personal & professional development and teaching strategies.
Cahill (1997)	Focus group and individual semi-structured interviews **Focus- Preliminary study to explore key areas of workload of nurse teacher**	57 including 6 college managers, 16 nurse teachers, 5 educational commissioners, 8 clinical assessors, 8 students, 9 post-registration students, 1 ENB officer and 8 higher education staff	A wide range of functions identified at specific organisational levels – college, departmental, site, course, individual personal development and external
Brown et al (1998)	Qualitative one to one and focus interviews relating to perspectives of trained nurses and students about the nurse teacher role in the clinical areas of mental health and learning disabilities **Focus: The nurse teacher role in the clinical area**	12 charge/ward sisters, 13 staff nurses and five focus groups of 2nd and 3rd year student nurses	Different models were discussed about the clinical role of nurse teachers. Staff and students wanted a nurse teacher who was both 'supportive and supervisory' and 'was able to relieve student anxiety' when required.
Clifford (1999)	Qualitative interviews reported in Clifford (1995). **Focus- a framework for clinical role of nurse teacher**	10 interviews in a college of nursing	Need for 'role clarity' and 'fitting in' important to working relationships. Role justification was low with respect to clinical role. Framework devised from findings.

Davies et al (1996 pp26) in a survey of nurse teachers found a wide range of both actual and potential roles. These included:

- Liasing with the college and practice areas
- Acting as 'ambassadors' for education
- Dealing with 'problems'
- Giving support
- Monitoring the learning process, mentors and students process
- Identifying staff training needs and keeping staff updated
- Negotiating placement allocations
- Participating in the assessment process
- Clarifying the role of practitioners
- Helping students to achieve objectives
- Encouraging appropriate continuing professional development

However, Davies et al (1996) found that there was little or no practice teaching performed by nurse teachers both in terms of students and preparation information of staff. One member of the clinical staff from the study felt this was responsibility of nurse teachers;

'I imagine the teaching staff should be leading with their knowledge and enable us to carry out our role. Do you know what I mean? You ask them (nurse teachers) for advice and you get 'Ummms' and 'Ahhs'. (Davies et al 1996 pp25).

The literature revealed that one evident feature of the nurse teacher role is the debate about the clinical role. According to Gerrish (1992), the clinical learning environment is of vital importance to the student and the clinical role of nurse teachers is essential if the discrepancy between what is taught in the classroom and what is practised in the clinical area is to be reduced. Therefore, much literature highlights the conflict between nurse teachers trying to fulfil both a classroom/academic role and clinical teaching role. Gerrish (1992) added that this

was 'the most problematic aspect of nurse teacher role' and that 'nurse teachers seldom teach in the practice setting'.

The ENB (1989) indicated that all nurse teachers should be 'clinically up to date' and be therefore 'clinically credible'. However, in being clinically credible, a practitioner has to keep clinical skills 'up to date'. In order to fulfil their clinical role a number of clinical link schemes have been organised including examples such as joint appointments (Elliot 1993) and lecturer/practitioner roles (Woodrow 1994a, 1994b and ENB 1996a). Some of these schemes have included nurse teachers being responsible for a number of wards/areas of clinical practice liasing with both staff and students (Clifford 1995a).

All the schemes were highlighted as 'problematic'. In several studies on this issue, nurse teachers reported that when there are other educational commitments such as teaching in the classroom, meetings, administration and courses to be attended, these links are hard to maintain and in some cases dropped entirely (Clifford 1995a, Coad 1994). Other authors argue therefore against nurse teachers being involved in clinical practice suggesting that the role is unrealistic and advocate for a role where the nurse teachers take their educational expertise to the clinical area. In this way nurse teachers aim to act as a valuable resource to clinical staff at a strategic level of operation (Coad and Devitt, 2000).

Several studies obtained views of clinical staff about the expected clinical role of the nurse teacher. Examples include Owen (1993), Jeffree (1991), Baillie (1994) and ENB (1996a) but was more comprehensively explored by Clifford (1992, 1993, 1995a, 1995b, 1996a, 1996b and 1999). Following 40 pilot interviews in 1992 and 1993, which sought to explore the nature and preparation of clinical link role, Clifford (1995a) performed a survey using questionnaires with 245 nurse teachers in four colleges of nursing (126 returned). She found that nurse teachers undertook specific work as part of their role.

A useful framework was thus devised by Clifford (1995a) from the trends identified:

- Respondents profile including professional, academic, career pattern, reasons for entering nurse education and preparation for nurse teacher role.

- Positive and negative aspects of working in nurse education

- Teaching role in the classroom

- Management and administration role

- Clinical role including links with clinical areas, factors influencing visits to clinical areas, length and frequency of clinical visits, nature of clinical role, relationships with clinical staff

Clifford (1995b) followed up the survey with ten in-depth interviews of nurse teachers in one college of nursing to find that only two were 'linked' to an area in which they had clinical expertise, the remainder had links which were given to them by organisational needs and direction. Time spent in the location was variable

reflecting previous work (Jeffree 1991, Crotty 1993, Jowett et al 1992) and the problem of 'not being able to pop in' to the location prohibited visits.

Clifford (1996b) later used the theoretical framework of Biddle and Thomas (1966) and Hardy & Conway (1988) presented below to analyse the findings and concluded that specific prepositions related to the nurse teacher role:

- **Role Clarity** – the ability of a nurse teacher to fulfil a clear focus to the clinical role. It can be high if a clear focus to work exists and low if it does not.

- **Fitting in** – the way in which a nurse teacher attempts to demonstrate he/she has an insight into the mechanisms of care and is credible to 'do nursing'.

- **Role Justification** – Found amongst nurse teachers who lack role clarity and tend to justify why their clinical role had not developed, as they would like.

Clifford (1996b) found that most of the nurse teachers lacked role clarity as only two were able to give a clear focus about their role in clinical practice and therefore this resulted in an ad hoc approach to the work. As a consequence, Clifford (1996b) suggested that nurse teachers developed 'fitting in' strategies such as working the shift patterns of ward team, demonstrating that they could still undertake clinical skills such as bed-making to try to fit into the ward team.

In terms of role justification Clifford (1996b) also noted that those who felt they had a clearly identified clinical role did not seek to justify the role whereas other nurse teachers used reasons such as organisation demands, time, administration and management and teaching commitments. Arguably, Clifford's (1995a, 1995b, 1996a and 1996b) work was undertaken prior to the merger into higher education, but the findings are pertinent as background to the expected and conflicting attributes of the nurse teacher role.

Further projects exploring the attributes of the nurse teacher role include McElroy (1997) and Cahill (1997). McElroy (1997) used a focus group method with 10 groups of nurse teachers (n=52) and from the key words and phrases identified specific themes which nurse teachers felt the role entailed. These included:

- **Theme 1** - clinical links
- **Theme 2** - time to think and reflect
- **Theme 3** - personal tutor
- **Theme 4** - teaching strategies

Clinical links were found to support other studies outlined but what was interesting and pertinent to the study reported here were themes 2,3 and 4. McElroy (1997 pp 147) found that 'time to think and reflect' and 'varied teaching strategies' were important to nurse teachers personal & professional development, but were fraught with difficulties such as 'the rapid pace of change', limited time and inadequate peer support. Equally, the role of personal tutor resulted in varied debate as nurse teachers used several models of student support. These included one to one tutorials

or group, length of times for a tutorial, having larger groups of nurses and whether teachers should act as a counsellor to student problems or not.

Cahill (1997) whose study aimed to explore key areas of workload of nurse teacher found that the role of nurse teacher was much wider and diverse than McElroy (1997). This may be due in part to the breadth of her sample that included 57 (6 college managers, 16 nurse teachers, 5 educational commissioners, 8 clinical assessors, 8 pre-registration students, 9 post-registration students, 1 ENB officer and 8 higher education staff). The findings revealed the nurse teacher works at specific organisational levels including:

- College/Departmental
- Site
- Course
- Individual student
- Personal development and External

Following further review of the functions of the nurse teacher role participants identified the following categories:

- Academic teaching
- Clinical teaching
- Academic/clinical links
- Administration
- Personal development (& attributes)
- Student welfare
- Other

Overall, the work of Clifford (1995a), McElroy (1997) and Cahill (1997) were the most useful in terms of their findings provided frameworks from which to review the nurse teacher role. Whilst each framework approached the nurse teacher role differently issues of commonality emerged such as conflicts related to the expected clinical role. Although other work such as Jeffree (1991), Owen (1993) and Baillie (1994) had limited relevance to this study due to limited breakdown of the nurse teacher role attributes they did help provide a wider picture of the nurse teacher role.

3.4.3. Studies related to the impact of Project 2000 (prior to the merger into higher education)

One noticeable educational change was witnessed in the Project 2000 programme and therefore it needs exploring in the context of the impact on nurse teacher role (Table 3.3). Several studies identified that the Project 2000 programme had a profound impact on students, teachers and clinical staff (Robinson 1991, Crotty 1993, Jowett et al 1992, White et al 1993, Luker et al 1993,1996, Carlisle et al 1996,1997 and Camiah 1996). Three of the studies (Crotty 1993, Luker et al 1993,1996 and Camiah 1996), however, explored the impact of change on the nurse teacher role in depth and consequently were most relevant to this study.

Table 3.3. Studies of Nurse Teachers into the impact of Project 2000 (Specifically with respect to the impact of change on the nurse teacher role)

Author/date	Study details	Sample (n =)	Key issues identified
Robinson (1991)	Delphi study **Focus – student teacher and clinical staff**	Sample not stated	Recommended that in the light of change role should be reviewed and formalised as a 'facilitator' to create a professional development role
Crotty (1993)	Delphi survey **Focus – nurse teacher role in the light of the impact of Project 2000**	201 nurse teachers (Grade 2) in one school of nursing and midwifery	Transition of role to a Diploma level teacher would create new opportunities and challenges Concluded that educational and managerial demands were increasing. Impact on research role of nurse teachers
Jowett et al (1992)	Longitudinal study using interviews **Focus- Impact of Project 2000**	6 districts with nurse teachers, students and clinical staff	Lack of role clarity and increased stress. Nurse teachers felt they were pulled in several directions (academic versus practical demands)
White et al (1993)	In depth evaluation study **Focus – Evaluation of the impact of Project 2000**	(17 nurse teachers in delivery of adult branch programme and 8 in mental health nursing)	Lack of role clarity = that the change increased strain on nurse teachers. Sense of powerlessness about the change and impact on role. Sense of survival.
Luker et al (1993, 1996) Carlisle et al (1996,1997)	Both reports form part of a ENB evaluation project using a Delphi survey (focus groups) and telephone interviews during 1991-1994 **Focus: Nurse teacher role as a result of Project 2000**	Main sample were a random sample of 600 nurse and midwifery teachers	Academic status of higher education seen as desirable but problems of contracts identified Lack of preparation for change and unclear roles ('Jack of all Trades') would make nurse teacher vulnerable

Author/date	Study details	Sample (n =)	Key issues identified
Camiah (1996)	Qualitative interviews across two determined Project 2000 districts over a 15 month period with educational staff and qualified clinical nurses **Focus: to explore the perceptions of key informants about the impact of Project 2000 on nurse teacher role**	73 educational staff including nurse tutors, senior tutors, higher educational lecturers, ENB officers and heads of nursing schools. 42 clinical staff including nursing practitioners, senior nurses and service managers	Nurse teacher role had become more complex and diverse. Nurse teachers were expected to consider alternative approaches to teaching and learning and that there was an increased development of subject specialisation Also found nurse teachers had to develop new creative initiatives such as consultancy and research activities.

Crotty (1993) undertook a Delphi survey with 201 nurse teachers in one school of nursing and midwifery in order to explore the nurse teacher role in the light of the impact of Project 2000. With respect to the impact of change on nurse teacher role she found that teaching Diploma level created new opportunities and challenges for nurse teachers. She concluded that educational and managerial demands were increasing and that the 'new' role would result in an increased emphasis on the research role of nurse teachers.

Luker et al (1993, 1996) and Carlisle (1996; 1997) added to this picture in that they both reported on a ENB evaluation project using a Delphi survey with focus groups and telephone interviews during 1991-1994 as one college implemented Project 2000 and 'linked' to one HEI. They asked questions about the perceived 'advantages' and 'disadvantages' of nurse teachers (pp27-28), which they suggested

was a very useful framework to subsequently analyse results. Findings indicated that nurse teachers' felt that one advantage was that the links into higher education would improve the academic status of nursing and that of 'nurse teacher' would also improve.

Conversely, several disadvantages were identified. One was the higher education contract, which might be offered. Nurse teachers felt that their unclear roles ('Jack of all Trades') would make them vulnerable and any contract offered by HEIs would result in inequalities to the existing nurse lecturers in the institution. Arguably, resistance to the full transfer into nursing was manifesting at this stage. Other disadvantages identified in Luker et al (1993, 1996) were the pressures of the lack of preparation nurse teachers felt they had for the delivery of the Project 2000 programme, and the increased workloads and demands since implementation. This had resulted in increased role stress and strain supported by previous work (Jowett et al 1992; White et al 1993).

Camiah (1996) undertook a different approach in order to explore the impact on nurse teacher role of Project 2000 as she chose to use an in-depth case study approach. The study was centred upon two contrasting districts that provided Project 2000 programmes using the key informant interviews over 15 months with nurse teachers and service staff. Camiah (1996) found that as a result of Project 2000 initiatives the nurse teacher role had become more complex and diverse. Nurse teachers were expected to consider alternative approaches to teaching and

learning due to larger class sizes such as increased student-centred teaching and that there was an increased development of subject specialisation such as sociology, psychology and physiology. The study also found that nurse teachers had to develop new creative initiatives such as consultancy and research activities and was excellent background for the study reported here.

3.4.4. Studies of Nurse Teachers role after 1990 (following the merger into higher education)

Arguably, the nurse lecturer 'role' was established in some of the polytechnics and universities prior to the merger but they did not exist in the large numbers witnessed since. The merger of colleges of nursing into higher education institutions changed this and challenged traditional titles. Prior to the merger, nurses working in education were known as nurse tutors or nurse teachers but new titles include 'lecturers in nursing' or 'nurse lecturer'. This is complicated by the grade attributed to a post holder which can be that of Lecturer, Senior Lecturer or Principal Lecturer depending on awarding institutions, job contracts and/or levels of responsibility, an aspect which is discussed more fully in Chapter 4. Other differences in the contract, preconditions and subsequent responsibilities of nurse lecturers are also interesting and have been included in here to set the scene (Table 3.4).

Table 3.4. Differences in criteria for pre-merger nurse teachers and post merger new nurse teachers

Nurse teacher role in NHS **(Pre merger nurse tutor)**	**Nurse teacher role in higher education** **(Post merger nurse lecturer)**
• Role evolved in the NHS	* Role evolving in higher education
• Entered nurse education after 3 years professional, clinical experience and senior position in practice	* Professional background experience not clearly specified until 2000 (ENB/ UKCC)
• Graduate status not essential on entry (First level practice minimum)	* Graduate status essential on entry. (First level practice minimum) Masters preferable
• Worked in nursing schools and college settings under NHS management with strong clinical links	* Work in higher education institutions with clinical links - variety of models
• Compulsory preparation in ENB approved courses	* Compulsory preparation in ENB approved and standardised courses
• All graduate profession only from 1995	* Courses are organised via The Institute of Learning and Teaching in Higher Education (ILT). Teaching programmes are a mixture, organised by the HEI internally as the employing university, some of which are ENB approved.

(adapted from Lovett & Walker, 1998).

Although there exists a body of literature pertaining to nurse teacher role largely all the studies of nurse teacher role were as might be expected, performed in colleges of nursing prior to the merger into HEIs. There have also been several key pieces

about the possible effects of the integration into higher education, but many have included literature reviews, case study or discussion as opposed to rigorous investigations (Lee 1996, Draper 1996, Miers 1997, Brown et al 1998, Rodriguez & Goorapah 1998, Ioaniddes 1999, Humphries et al 2000, Murphy 2000, and Smith & Gray 2001). The limited research found included Barton (1998) ENB (1998b) Evers (2001) and Clifford et al (2001), which specifically focused on nurse teacher role, is summarised in Table 3.5 and will be discussed in this section.

Table 3.5. Studies of Nurse Teachers since the merger into higher education

Author/date	Study details	Sample (n =)	Key issues identified
Barton (1998)	Qualitative project of nurse teachers who had transferred into higher education vs. lecturers in existing nurse delivery posts **Focus – To examine the complex issues pertaining to nurse and midwifery teachers transferring from a college of nursing to one institute of higher education**	Two samples of nurse and midwifery teachers organised via a systematic random sampling technique – **21** in group A and **17** in group B. **Six** university academics were interviewed.	The merger event caused considerable stress and anxiety to the group of nurse and midwifery teachers. Resulted in a higher degree of role conflict and that the gap between theory and practice may be widening due to the nurse teachers' adaptation to the new expected roles.
Day et al (1998) ENB	National qualitative and quantitative questionnaire in five stages over 18 months **Focus- The role of the nurse teacher in practice and to 'map' the national picture of nurse lecturer in practice following merger into HEIs.**	Phase 1= team sent 373 questionnaires to Heads of Schools (n=50), Programme leaders (n=250), Heads of Service (n=49) and Deans of Faculty (n=24). 246 (66%) responded. Phases 2-5 = qualitative data used interviews and case study approaches	A variety of models were found across the national picture. Increased workload as a result of the merger into higher education and lack of time. Recommended urgent strategic review of link role of nurse lecturers.

Author/date	Study details	Sample (n =)	Key issues identified
Evers (2001)	RCN commissioned survey using quantitative questionnaires across U.K. and follow up qualitative focus groups. **Focus to explore the nurse teachers' role across the U.K. in terms of 'common' role attributes and workload issues.**	From 8,600 questionnaires distributed (via RCN publication of Edlines) - 703 responded but only 573 could be utilised. Follow up focus groups – 25 lecturers from two RCN conferences as 'fringe' events.	Issues related to workload, clinical time, student support, contractual status, and role conflicts. Areas were ranked as to priority and findings highlighted complexity of role.
Clifford et al (2001)	Questionnaire survey using the work of Clifford (1995a). **Focus - to map the range of activities performed by nurse lecturers in their role in the West Midlands region.**	166 questionnaires sent to four of the seven West Midland universities who deliver nursing courses. Response rate = 36.1% (60)	Mapped out biographical data, qualifications, career structures, preparation for role, role attributes (classroom, clinical research), working relationships with NHS and future role development

Barton in 1998 undertook one of the earliest studies after the merger into HEIs aiming to explore role conflicts that a group of nurse and midwifery teachers experienced as a result of the merger into higher education. Barton (1998) focused the study on 38 nurse and midwifery teachers as they transferred from working in one college of nursing in the NHS to a department of health studies in a HEI. The methodology included a range of qualitative approaches drawing heavily on the principles of phenomenology. Barton (1998 pp1286) concluded that nurse teachers felt 'a sense of marginalisation' from changing from working in a college of nursing in the NHS to working in a higher education institution. They felt they identified

less with the NHS and links with clinical areas became more problematic as they were also establishing themselves within a university setting. Consequently, the nurse teachers in the sample felt a rise in 'role conflict' particularly witnessed in clinical role. Barton (1998) suggested this fell into two main issues. Firstly that the nurse teachers felt they were less able to go to the clinical areas due to lack of time as a result of a role change and on the occasions they did visit clinical staff reiterated that they were upset at the loss of this role. Secondly, the nurse teachers felt personal clinical credibility and expertise was becoming 'eroded'.

Clifford (1997a) had previously predicted anxiety and conflict could arise related to nurse teacher's research expertise as a result of the merger into higher education. Clifford's (1997a) predictions were also explored by Barton (1998) with existing university nursing lecturers who had come into direct contact with the new nursing department. Barton (1998) found that whilst the university academics were not particularly concerned about nurse and midwifery teachers transferring into higher education they expressed anxiety over their lack of research background. Barton (1998) noted that this was essentially due to two reasons; firstly that the nurse teachers would lack formal teaching about research and secondly, that this would affect the research rating of the university and subsequent resource availability. Although the sample was small and limited to one area, Barton's (1998) findings were most useful to the study reported here. This was because he demonstrated that the transition from working in a college of nursing in the NHS was different to

working as a lecturer in a HEI and that this could impact on the future nurse teacher role.

A comprehensive national study of nurse teacher role after the merger into HEIs was also performed by the Day et al (1998). The focus of this study was to explore the clinical role of the nurse teacher in order to 'map' out the national picture of 'nurse lecturers' following the merger. This 18 month project investigated the role of lecturer in practice in midwifery and the four branches of nursing in both institutional and community contexts. In order to undertake a phased approach was used and at Phase 1, the team sent out 373 questionnaires to Heads of Schools (n=50), Programme leaders (n=250), Heads of Service (n=49) and Deans of Faculty (n=24). Of this sample 246 (66%) responded, resulting in an excellent response rate. The qualitative data was collected using interviews and case study approaches at the subsequent phases (2-5) of the study. The findings revealed that a variety of models were found across the national picture for link lecturer role. With specific reference to nurse teachers, the report (Day et al 1998) noted that workload had substantially increased as a result of the merger into higher education which resulted in a 'lack of time' to undertake all the expected duties. Subsequently this resulted in detrimental effects on the ability of nurse lecturers to maintain clinical credibility, support continuous clinical practice and further develop practice–based research. Thus, they recommended that an urgent strategic review of the role of nurse lecturers be undertaken.

Such a process began within the Royal College of Nursing by Ball (1998). Ball (1998) undertook a comprehensive literature review and found that 'ongoing research is this area is very limited and yet urgently needed'. Ball (1998) thus recommended that a national survey of nurse teachers' role in HEIs should be urgently performed and set out questions for consideration, which included:

- Who should be included in such a survey and why?
- How might a sample be identified and drawn?
- What are the issues that can and cannot be addressed by a survey?
- What is the context within such a survey would be undertaken?

Despite Ball's (1998) recommendations no survey was commissioned, but in 1999 following the concerns raised in the publication of the UKCC (1999) report, as outlined previously (Chapter 2; Section 2.6.1.), the RCN commissioned Evers (2001) to review the nurse teachers role in HEIs. In focusing the background of the study, Evers (2001) also found that limited research had been undertaken since the merger of nurse teachers into higher education and so undertook review of RCN conference papers to provide background to the study. This included papers, which related to student experiences of higher education (Costello 2000, Kevern 2000); attrition rates and student nurse characteristics (Hickey 2000, McCarthy 2000, Glossop 2000 and Worthington 2000) and specific programme based issues such as problem based learning (Randle 2001, Coe 2001, Morris 2001 and Cuthbertson 2001). Evers (2001) concluded that very few key pieces related specifically to nurse teachers role and that this was indeed disturbing, a point also found by Coad and Devitt (2000) and Clifford et al (2001).

The extensive survey subsequently performed by Evers (2001) used quantitative questionnaires, which were distributed across the U.K. via the RCN publication of '*Edlines*'. From the 8,600 questionnaires distributed 703 nurse lecturers responded but only 573 were analysed due to issues of instruction error. The findings were analysed into priority areas across 'high', 'medium' and 'low' and followed up as focus interviews of 25 lecturers during two RCN conference 'fringe' events (Evers 2001 pp15). Issues related to workload, clinical time, student support, contractual status, and role conflicts, as presented in Table 3.6.

Table 3.6. Nurse teachers in higher education study (Evers 2001)

Priority Area	Findings
'High priority'	Workload (82.2%) Role (54.1%) Clinical Time (51%)
'Medium priority'	Student Support (51%) Morale (47.3%) Integration and status (38.7%)
'Low priority'	Contractual Status and conditions (50.8%) Job Security (63.9%) Union representation (71.9%)

Evers (2001) found that the high priority areas of workload issues related to increasing student numbers, the extended teaching year and multiple roles that nurse teachers felt that they had to undertake which compromised specialisation. Clinical practice was not seen as valued in HEIs and so it was felt to be difficult to maintain competence. Lecturers suggested that the culture shock of higher

education had not been fully explored and greater integration strategies were needed. Overall, Evers (2001) recommended that greater collaborative strategies and shared vision was needed between the many stakeholders of nurse education in order to chart a way forward for lecturers of nursing in higher education.

Evers (2001) findings were supported by a further study undertaken by Clifford et al (2001) who was commissioned to map the range of activities of the nurse lecturer role across a defined regional area. The focus of this most recent study was to map the range of activities performed by nurse lecturers in their role across the West Midlands region. A questionnaire survey method was used building on the work of Clifford (1995a). Of the seven universities sampled, four participated and represented a range of universities. Of the 166 questionnaires sent 60 (36.1%) were returned. The findings included biographical data, qualifications, career structures and preparation for the teacher role also highlighted in previous literature. What was useful to this study was that Clifford et al (2001) found that nurse lecturers, who responded, struggled to meet the demands of their role namely those attributes associated with classroom, theory-practice interface and research activity. Interestingly, whilst respondents gave a favourable picture overall of their new roles in HE, future role development was considered to be limited by the actual time nurse lecturers had. A further observation to note was that working relationships with NHS were being established at the time of the study so it would seem worthwhile to review this aspect at a future point. As a result of such role conflicts, Clifford et al (2001) recommended that further study and full strategic review was

needed in order to develop new models of working and hence greater role clarity for nurse lecturers working in HEIs.

One further suggestion which has emerged in each of the studies analysed here (Barton 1998, ENB 1998b, Evers 2001, Clifford et al 2001) is that redundancies of nurse teachers were high prior to and at the merger into higher education as identified in this review (Chapter 2; Section 2.7). This brings specific considerations relating to responsibilities of nurse lecturers who may find there is less senior managerial nurse teachers to help support, mentor and generally develop their skills. Some writers have also indicated that as student numbers continue to rise recruitment for 'new' nurse lecturer posts may not be meeting the educational demand for student support. As a consequence this may add to increased responsibilities and potential stress. It is thus clear from the studies reviewed that the merger into higher education has impacted on the ability of nurse teachers to fulfil their role and that further studies are warranted (Barton 1998, ENB 1998b, Evers 2001 and Clifford et al 2001).

3.5. Summary

It is essential that if any profession is to develop and evolve that the role is continually reviewed (Biddle & Thomas 1966). The review to date has highlighted that the nurse teacher role evolved as a response to the changing nature of health care and due to the changes in delivery of nurse education. It was not an overnight 'big bang' but rather a gradual development and response to policy directions over a ten to fifteen year period. In the first instance this was clearly the NHS need for teaching nursing at the bedside and through the development of preparation courses for the role of nurse teachers. More recently during the 1990's the need for nurse teachers to be situated and employed by HEIs instead of in the auspices of colleges of nursing in the NHS created new demands.

Several earlier studies highlighted that the nurse teacher role was multi-faceted with unclear general attributes creating a platform for dissatisfaction and stress (Sims 1976). Others studies specifically analysed the role with respect to clinical expectations of nurse teachers in comparison to the clinical staff and were found to be often different (Crawshaw 1978, Sheehan 1981). Time spent on clinical role varies considerably from nil to many hours (Nolan 1987, Coad 1994, Clifford 1995a). Despite the complexities of nurse teacher role attributes specific pieces of literature such as Davies et al (1996), Clifford (1992, 1993, 1995a, 1995b, 1996a, 1996b & 1999), Luker et al (1993, 1996), Camiah (1996), Barton (1998), Evers (2001) and Clifford et al (2001) can be used to isolate common re-occurring role attributes and develop a framework for this review including:

- Classroom Role
- Student Issues
- Clinical Role
- Management / Administration
- Personal attributes

Although role attributes can be identified, what was less clear is the actual characteristics of the expected role. In short, what is expected versus what is actually delivered (i.e. what nurse teachers do and do not do). Some of this would seem to originate to the lack of understanding about the outcomes of the nurse teacher role. Thus, it may be argued that role clarity is essential to examining expected role outcomes.

One observation noted was that prior to and after the merger into higher education the terms of 'nurse teacher' and 'nurse lecturer' are used interchangeably in the literature. However, the impact of the title change is still not fully understood and indeed, the concept and expected role of a 'nurse lecturer' may be relatively new in many institutions. Morse (1996) suggests new concepts are likely to create problems related to 'a lack of conceptual clarification' leaving them vulnerable and easy to manipulate. Alternatively, it may be that there is little or no differences in the expectation of the role of 'teacher' in comparison to that of 'lecturer' but no work was available that explored these concepts. Therefore it was felt useful to analyse these aspects further in undertaking the concept analysis discussed in the next chapter.

Chapter 4

A concept analysis of the Nurse Lecturer

4.1. Introduction

The previous chapter illustrated that the nurse teacher role is complicated and multi-faceted and that the nurse lecturer's role within the HEIs could bring new role challenges. In this role transition nurse teachers changed their title from that of 'nurse tutor' to that of 'lecturer in nursing' (or nursing lecturer). Initially, a review of the literature indicated that there was some recognised common conceptual understanding of the term of 'nurse teacher' but it was clear that the attributes of the role were not well delineated and studies were subsequently limited in defining the parameters (Morse et al 1996, Clifford 1996b). This chapter, therefore, will analyse the term of 'teacher' and surrogate term of 'lecturer' in the form of a concept analysis in order to relate this to the role qualities of nurses teaching in HEIs today.

4.2. Concept analysis

Wilson (1969) suggests the purpose of a concept analysis is to give framework and purposiveness to thinking that might otherwise meander indefinitely. In undertaking a comprehensive breakdown of the concepts, meaning can be made of the associated features and enable the theoretical basis to an investigation to be formed (Morse et al 1996, Medlin 1989). In short, purpose can be thus given to the study of a given topic.

Walker & Avant (1995) support this suggesting that a concept analysis is useful for several reasons: to refine ambiguous concepts in theory; to help clarify over-used vague nursing concepts; as an instrument for research development and evaluation and help produce operational definitions or diagnosis. Given the literature reviewed in the previous chapters, these reasons apply to the study reported here.

Morse et al (1996) additionally notes that concepts are evident at different levels of maturity ranging from new concepts where two or more ideas may compete to explain a phenomenon. Alternatively, a more mature and accepted concept that receives a degree of consensus about its meaning may be identified. To reach such a consensus, Morse et al (1996) suggests a wide review of the literature and a process of thorough evaluation by the researcher using a framework of accepted criteria.

A variety of approaches can be used in undertaking a concept analysis, one of which is that suggested by Walker and Avant (1995) who modified the work of Wilson (1969) in adapting an eleven-stage model to an eight-stage process (Appendix 2). Other writers have criticised the Walker & Avant (1995) model for its rigidity and lack of conceptual, dynamic change, which naturally occurs (Rodgers 1989, Chinn & Kramer 1995, Morse et al 1996).

Alternatively, Rodgers (1989) suggests a cyclical approach as she felt that a more radical, evolutionary analysis was required to reflect the dynamic changes that occur over time (Appendix 3). Rodgers defines a concept as

'An abstraction that is expressed in some form either as discursive or non-discursive. Through socialization and repeated public interaction a concept becomes associated with a particular set of attributes that constitute the definition of the concept' (Rodgers 1989 pp332).

From the perspective of the nurse teacher, a range of titles used to describe the role included 'nurse tutor', 'sister tutor' and 'nurse teacher', as highlighted in the previous chapters. All of these terms related specifically to a nurse working in an educational role in a NHS school (later college) of nursing. This title has changed for nurse teachers who have now transferred their work to the higher education sector; where they are referred to as lecturer, nurse lecturer or lecturers in nursing. The ENB (1998b) report gives a useful insight into the issue of titles, indicating that the majority of nurse working as lecturers in HEIs do so as lecturers or senior lecturers, although here exists some ambiguity as 'new' universities graded their staff at senior lecturer levels.

Given that different titles and the dynamic nature of the role may impact on perception it is essential that these concepts be fully understood. To explore this further the method suggested by Rodgers (1989) was adapted in this investigation to explore this further as identified in Table 4.1.

Table 4.1. Framework for concept analysis - adapted from Rodgers (1989)

1. Identify and name the concept of interest
2. Identify surrogate terms and relevant uses of the concept
3. Identify the attributes related to the concept
4. Identify the references, antecedents and consequences of the concept
5. Identify related concepts
6. Identify a model case of the concept, if appropriate

4.2.1. Identify and name the concept of interest

Morse et al (1996) noted that a concept analysis is limited if the concept is not firstly clearly identified and named. In doing this, the concept must be broken down to a simple word in order to build up a picture and subsequent understanding (Appendix 4). Therefore, to inform this review the starting point was to analyse the term 'teacher'.

Dictionary definitions provide a useful starting point to breaking the concept into parts. The word 'teacher' was first examined, therefore, using the Oxford Twentieth Century Dictionary (1992), which helped to identify key concepts of 'teacher' and 'lecturer' that could be broken down further (Appendices 5 and 6). This process was helpful in providing a definition of a teacher as summarised in Table 4.2.

Table 4.2. Definition of a teacher

1. One whose profession is to show, direct, guide, counsel and give instruction.
2. A person whose talent is to impart knowledge.
3. A person whose practise is to give instruction and guide studies of the group.

From the dictionary definitions, the word 'teacher' had a well-established definition, both in terms of cohesiveness and consistency (Curzon 1990). Thus, the notion of a 'teacher' is one who passes on knowledge to others, who instructs and subsequently manages learning for others. In this way, the teacher performs the act of teaching in order to induce learning through many strategic activities in a deliberate and creative environment (Curzon 1990, Child 1991, Kyriacou 1991, Burnard 1992). Further evidence was found in the explanation provided by Davies (1971pp20) who stated that 'a teacher is a highly skilled professional whose teaching activity occurs both within and outside the classroom environment'. Therefore, in all the definitions used here, it is the teacher and their teaching activity that induces learning. However, in many respects these definitions are idealistic models as in reality many teacher variables affect the passing on of knowledge such as personality, class size, time and environment (Curzon 1990).

4.2.2. Identify surrogate terms and relevant uses of the concept

Following the model, surrogate terms need to be explored (Rodgers 1989). Using *Roget's Thesaurus* some of these related to teacher are presented in Table 4.3.

Table 4.3. Surrogate terms of 'teacher' (Roget's Thesaurus)

Teacher –
preceptor, mentor, guru, instructor, tutor, coach, leader, governor, governess, counsellor, educationist, pedagogue, abecedarian, master, schoolmaster, principal, schoolmistress, school-marm, lecturer, reader, professor.

It was relevant to the study reported here that lecturer was identified as a 'surrogate term' as this is the term by which nurse teachers are referred to in higher education (i.e. 'Nurse Lecturer' or 'Lecturer in Nursing'). It is important, therefore, to explore whether any differences exist in the meaning of this term. The Oxford Twentieth Century Dictionary (1992) defined a 'lecturer' as:

> ***one who lectures: a college or university instructor'***

This definition is developed by Turvey (1999) who suggests that a lecturer is a professional person with extensive knowledge in their subject who encourages the intellectual or vocational skills of those whom they teach. In the Turvey (1999) explanation, however, there is little mention of the classroom (within or outside) as witnessed in Davies's (1971) definition cited on the previous page. It was also interesting to note that there were no references to the type of 'classroom' such as school or higher education equivalent and if this has any impact on the role

performed within that environment. Furthermore, whilst there was acknowledgement of pedagogy (teaching children) as opposed to andragogy (teaching adults) there were no references made about how teaching different groups impacts on the role of the lecturer in higher education as opposed to a teacher per se (Turvey 1999). Therefore, it was not clear from the work reviewed if the role of lecturer is any different from that of the role of teacher. It may be the case that it is not and indeed synonymous to lecturer using Roget's Thesaurus included 'teacher', 'speaker' and 'orator' (Table 4.4).

Table 4.4. Synonyms for lecturer (Roget's Thesaurus)

1. Teacher = preceptor, mentor, guru, instructor, tutor, coach, leader, governor, governess, counsellor, educationist, pedagogue, abecedarian, master, schoolmaster, principal, schoolmistress, school-marm, lecturer, reader, professor.
2. Speaker = public speaker, utterer, talker, orator, conversationalist, lecturer, broadcaster, elocutionist, preacher, delegate, spokesperson, pulpiteer
3. Orator = shrewd person, diplomat, public speaker

As the definitions cited here seemed both wide and generalised, further analysis of the word 'lecturer' was undertaken. In North America, Brew (1995) notes that 'lecturers' are clearly identified within any academic faculty. This was illustrated through the definition of 'faculty' given by the US National Center for Education Studies (NCES) (1995 pp3) in their glossary of terms:-

Faculty – 'Persons whose specific assignments customarily are made for the purpose of conducting instruction, research, or public service as a principal activity and who hold academic rank titles of professor, associate professor, assistant professor, instructor, lecturer, or any equivalent of any of these ranks'.

In order to relate the above definition to the U.K. relevant literature was reviewed about what constituted a lecturer in a HEI (Robinson 1968, Eggins 1988, Brew 1995). Clear levels of lecturers within HEIs in the U.K. could be found, within many schools of expertise and different organisational structures. With respect to the concept analysis, the bulk of teaching staff were given the title of 'lecturer', which was used to denote any academic member of staff who has studied up to first degree/Masters level. Brew (1995), noted that there are essentially two cultures amongst the staff in a university: firstly the academic staff and secondly what she terms the 'allied staff' such as clerical, technical and manual workers. However, she adds that academic staff could be sub-divided further as being an 'academic' might mean teacher, researcher or manager, and in some cases meant a combination of two or all three of these aspects. This she felt adds to role confusion and subsequent increased work related stress for such staff.

Within the academic staff, Brew (1995) also noted that whilst the bulk of teaching staff are termed lecturers, specific roles are identified in that a Lecturer title may be linked to the subject speciality. Clearly the term lecturer in the U.K. also denotes considerable expertise and extensive knowledge in a specialist field and is often a position that is 'aspired to' in that relevant profession (Brew 1995, Turvey 1999). In the U.K. the prefix 'Senior' or 'Principal' are only used to indicate a higher career grade. In North America the equivalent teaching grade to a lecturer is usually that of 'Professor', so this is used widely for the bulk of teaching staff (NCES 1995). But in the U.K. the titles only go beyond the titles of Lecturer, Senior Lecturer and/or

Principal Lecturer to that of Reader and Professor after considerable expertise in the field is demonstrated. Thus, in the U.K. Brew (1995) suggests a 'professorial chair' is viewed within the context of a hierarchical university model. This is supported by Draper (1996 pp215), who states that such chairs in the U.K. are 'invariably occupied by distinguished researchers'.

Candy (1991) suggests that frequently staff in HEIs are awarded titles as a result of the cultural history from which that higher educational institution evolved. As introduced elsewhere, following the removal of the binary line, which is discussed fully in Chapter 5 (Section 5.4.3.1), a university in the U.K. may be described either as 'old' or 'new'. Within this context, staff are given titles depending on the 'culture' of that university. Thus, the structure in 'new' universities identifies grades of Lecturer and Senior Lecturer whereas the 'old' universities distinguish between Lecturer A and Lecturer B. This complicates a review such as this as the titles are often also associated with a salary banding and expected role (Candy 1991, Brew 1995). In broad terms, for example, the salary of a Senior Lecturer in a 'new' university equates to that of a Lecturer B in an 'old' university. Lecturers may feel, however, that there are differences related to kudos. For example, is it preferable to have the title 'Senior Lecturer' to that of 'Lecturer' (Eggins 1988).

Furthermore, as a consequence of the merger, those nurse teachers who transferred into higher education were given titles within their 'old' or 'new' university structures such as lecturer, lecturer in nursing, senior lecturer, senior lecturer in

nursing, principal lecturer and principal lecturer in nursing, depending upon designated responsibilities (Clifford et al 2001). The impact of diversity of title is largely unknown but it is relevant to consider the effect of change on the title and whether this also has an impact on the expected role of nurse teachers. A recent publication of the Department of Education & Employment manual was reviewed in order to give comprehensive information on all the occupations represented within higher education (Turvey 1999 pp118-120). Each higher education occupation is singled out and differences identified, such as Therapeutic Radiology as opposed to Diagnostic Radiology. Higher education lecturing posts are included in the guide including a section on their titles such as 'Lecturer in Psychology' and the expected teaching role. Interestingly, there appeared to be no mention of nurse teaching as a role and no mention of the title of nurse lecturers. This may simply imply that the recent moves to higher education have not yet been reflected in the manual but may arguably reflect a failure of recognition of the nursing profession. It is also pertinent to consider the relevant uses and title of nurse teachers.

4.2.2.1. The relevant uses of the titles used for 'nurse teachers'

As highlighted in Chapter 2 (Section 2.8.2), in 1998, at the last ENB count, there were 4,851 nurse teachers employed in the U.K. (ENB 1998a). Norris (1982) suggests that, in searching for a concept, it is essential that it be examined as a whole as separation reduces unification. However, no dictionary definition could be found of the combined notion of 'nurse teacher' or 'nurse tutor' or 'nurse lecturer',

although associated words were examined including nurse, nursing, practitioner, lecturer and teacher, but did not yield any further result.

As outlined elsewhere, traditionally nurse teachers were known as 'Sister Tutors', this title being replaced by 'Nurse Tutors' in schools and colleges of nursing within the NHS. Turvey (1999) suggested that the term 'tutor' originates from the Oxford model of education whereby students were 'tutored' in small groups and that semi-professional occupations adopted the term to denote teaching skills in small groups.

From a sample of the literature, outlined in Chapter 3, it was noted that whilst many authors assumed the reader understood the meaning of nurse teacher or nurse tutor, only a few included a full definition (Table 4.5). Whilst work could be found that offered some definitions (DoH 1989d, ENB 1989, ENB 1990, DoH 1993, ENB 2001), arguably several were unclear about the required qualifications and experience. The only work found that clearly defined the nurse teacher was Buttigieg (1990), who at the outset stated that the 'a nurse teacher applied to teachers of nursing, midwifery, health visiting, district nursing and occupational health nursing' and included an explanation of the requirements for the role. Barton (1998), whose work related to the implications of merger of nurse education into HEIs referred to the group implicitly as nurse and midwifery teachers throughout. Others, such as Luker et al (1993, 1996) and Clifford (1995a, 1995b, 1996a, 1996b), also used the term of nurse teacher implicitly, whilst Camiah (1996) used nurse tutor exclusively and again implicitly throughout the work (Table 4.6). In

more recent work, the UKCC (1999) document refers only to the university lecturer or 'HEI providers' of pre-registration education. Evers (2001) and Clifford et al (2001) do, however, use the term nurse lecturers throughout, but only Clifford et al (2001) offers an explanation about the title change and the implications on role attributes.

Table 4.5. Literature defining the title of nurse teacher

Literature reviewed	Definition provided
DoH (1989d) DoH (1993)	Both documents defined a nurse teacher as a person who teaches nurses, midwives or health visitors and who must be both academically and clinically credible.
Buttigieg (1990)	Clearly defined a nurse teacher as a teacher of nursing, midwifery, health visiting, district nursing and occupational health nursing. Explains that nurse teachers are registered nurses, midwife and health visitors who hold relevant academic /teaching qualifications.
ENB (1989) ENB (1990) ENB (1996a) ENB (2001)	Teacher defined as professional nurses, midwives or health visitors who work with a teaching role.

Table 4.6. Literature using nurse teacher, nurse tutor or nurse lecturer implicitly

Literature reviewed	Definition provided
Jeffree (1991)	Nurse teachers and link nurse teacher used throughout the study to discuss role with no clear evidence of meaning of the titles.
Crotty (1993)	Nurse teachers used throughout. No definition of the nurse teacher included.
Luker, Carlisle & Kirk (1993, 1996)	Nurse teacher used implicitly whilst link lecturer used to denote 'individuals based in higher education institutions with whom colleges of nursing/midwifery have formed links for provision of a Project 2000 course'.

Literature reviewed	Definition provided
Clifford (1995a, 1995b, 1996a, 1996b) Clifford et al (2001)	Definition of nurse teacher implicit. More recent work related to nurse lecturer but an outline of the history of role/title is included.
Camiah (1996)	Nurse tutor used throughout with no definition.
Day et al (1998)	National study of the role of the nurse teacher but no titles explored and used 'nurse teacher /lecturer in practice' throughout.
Barton (1998)	Used nurse and midwifery teacher throughout and 'existing university staff' to denote the body of nursing and midwifery lecturers in the university before the merger.
UKCC (1999)	Glossary of terms included (pp55) and HEIs defined but no definition of teachers of nurses or midwives offered. Used term university lecturers as opposed to nurse or midwifery lecturer.
Evers (2001)	Nurse lecturers working in higher education was largely used. No definition or explanation offered.

There may be several explanations for this. The literature used in the review is predominantly from nursing sources where arguably it may be assumed that in order to be a 'nurse teacher' you have to first qualify as a nurse. Hence the title is understood and accepted within the nursing profession. The other titles of nurse teacher, nurse tutor or nurse lecturer (and subsequent status) are also assumed and do not need further explanation. Rodgers (1989) model of concept analysis supports the notion that this use of a title can subsequently equate to its acceptance.

The concern, however, is that that whilst the term assumes a common meaning in nursing it may not be a well-established concept outside of the profession of nursing. At the same time the title may be quite vulnerable as change occurs in the profession, such as might be witnessed in the merger into higher education institutions, where new titles of nurse lecturer or lecturer in nursing are designated. Carlisle et al (1997), therefore, suggests that in higher education, a lecturer who teaches nurses may not always be a nurse but may be another 'ologist' or 'specialist' such as physiologist or psychologist. This may be the reason for the title used in the UKCC (1999) document. In such cases, a teacher of nurses is not a nurse teacher. This raises a dichotomy of views. One argument is that this could make the nurse teacher more vulnerable in their role including issues about who supports students in clinical placements if there are less teachers who are nurses in the HE departments of nursing. However, others would argue that this strengthens the professional base of nursing and could potentially enhance multi-professional understanding and working together.

4.2.3. Attributes related to the concept

Morse et al (1996) suggest that searching for associated attributes is an important process in concept development and relates directly to the level of maturity of the concept. With respect to a 'teacher' there is a wealth of literature that discusses expected attributes. Child (1991) suggests that these include skills and experience. Earlier evidence was found to widen this definition, using Dunkin & Biddle (1974), who noted that any teacher will possess specific attributes known as presage

variables, which include aspects such as past experience, personality, beliefs and ideologies, learning style, teaching style and teaching skills. Past experience is directly related to expertise and will subsequently influence the teaching performance and the strategies the teacher employs (Meighan 1986). Kolb (1984) also suggested that teachers in their activity must utilise their past experience and in doing this create an environment of motivation. Personality of the teacher is also a complex concept and includes qualities such as temperament, communication, leadership, motivation, control, self-awareness,_mannerisms and humour, all of which equally affect teaching style and delivery (Child 1991, Kyriacou 1991). However, even if the teacher had all these listed qualities, if the pupil was not receptive in some way or felt that a 'personality clash existed', the relationship could adversely affect both teaching and learning activities (Child 1991).

In relating this literature to nurse teachers, several studies have sought to analyse the multi-faceted role of nurse teachers as outlined in Chapter 3, but to date fewer studies have analysed the role of the nurse lecturer in HEIs (Barton 1998, ENB 1998b, Evers 2001, Clifford et al 2001). For example, Crotty (1993), Luker et al (1993, 1996), Camiah (1996), Carlisle et al (1996, 1997), Clifford (1995a, 1995b, 1996a, 1996b, 1999) and MacNeil (1997) all analysed the role before the merger into HEIs.

A useful American survey was retrieved, however, which sought to explore specific nurse teacher attributes in a university faculty of nursing (Eason & Corbett 1990). Eason & Corbett (1990) identified specific characteristics which were thought to be 'effective teacher attributes' of nurse teachers in a university faculty. The study included 2,877 student nurses as participants, who were asked to document their perceptions of attributes related to the concept of a nurse teacher. Over 130 attributes were subsequently ranked in relation to frequency of responses. These attributes clearly demonstrated that expected nurse teacher attributes are complex and diverse. From the first list of 130 attributes a modified final list of 18 was identified that had had responses of a frequency of five or greater (Table 4.7). It is interesting to note that many of the attributes were related to personality attributes (at least 12) as opposed to academic and clinical nursing expertise.

Although Eason & Corbett's (1990) study supports U.K. studies reported earlier (Clifford 1995a, Nolan 1987, Carlisle et al 1996, Barton 1998 and ENB 1998b) it is thought provoking in identifying what student nurses expected of nurse teachers. Studies in the U.K., which were comparable to Eason and Corbett's (1990) work, were limited. Although Clifford (1995a) did undertake some preliminary interviews with student nurses, these were not to the same depth and consisted of group interviews only. It would seem essential, therefore, that research in the U.K. explores the expected nurse teacher attributes as perceived by those who come into contact with nurse teachers, such as clinical staff, students, doctors, other lecturers and health professionals (Clifford 1995a).

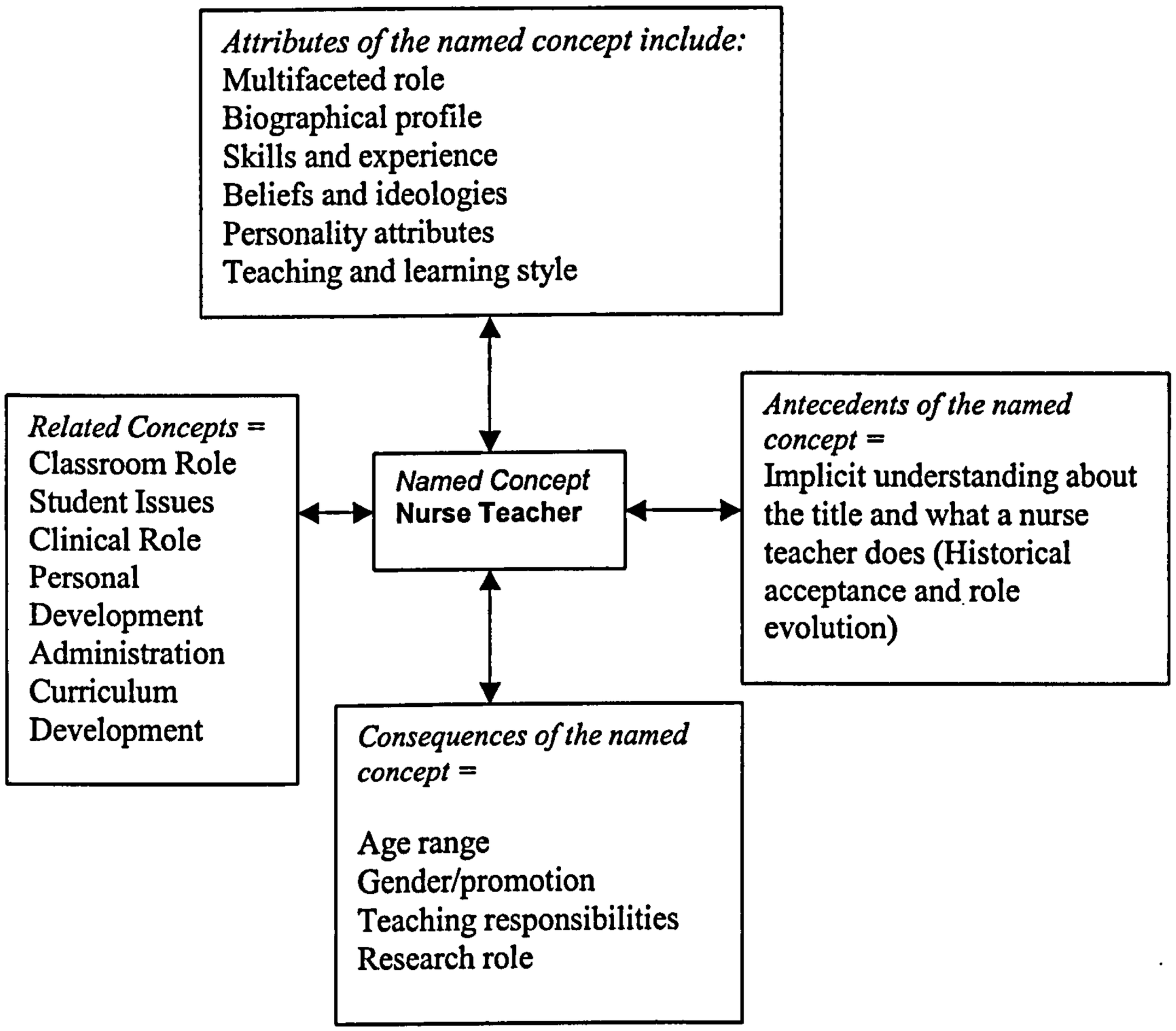
Table 4.7. Student nurses' perceptions of attributes related to 'Nurse teacher' (adapted from Eason & Corbett 1990)

Answered questions	Helpful
Audio visual/handouts	Informative
Clear/concise	Interesting
Dynamic	Kept my attention
Easy to listen to	Knowledgeable
Energetic	Realistic
Entertaining	Sense of humour
Enthusiastic	Shared their experiences
Used language we understand	Good examples/case studies

4.2.4. Identification of references, antecedents and consequences

In examining a concept Rodgers (1989) suggests that the analyst evaluates the 'references, antecedents and consequences' of the concept. A reference clarifies the position and application of the concept at the time of analysis, whilst the antecedents will take place prior to the occurrence of the concept and the consequences occur as a result of the concept (Wilson 1969, Norris 1982, Endacott 1997). This raises several issues and whilst these are developed elsewhere in the review it is worth outlining some of the issues. These have been presented in Figure 4.1.

Figure 4.1.
Antecedents, attributes, references, variables and consequences of nurse teacher



The antecedent literature to date has found that whilst there exists an implicit understanding in the profession about what the role of nurse teacher is, clarity about what a nurse lecturer does is lacking (Figure 4.1). Walker and Avant (1995) note that such a case is known as an evolving concept. Thus, the impact of this title change to nurse lecturer (and the expected role) is still evolving. What is also clear is that the there will be a status change as nurse teachers are integrated into a 'system where nursing has the same rights and privileges as other academic disciplines' (Draper 1996 pp215). This could affect, not only those nurse teachers who have transferred, but could also have recruitment and retention implications for practice-based nurses in the National Health Service entering into a higher education institution teaching post. This can only be an assumption, as the majority of the studies that explored the nurse teacher role, were completed prior to or at the merger into higher education and did not seek to explore the change in title and status as a cultural change.

Other specific issues have been expanded within the concept analysis to help understand more clearly the context of the nurse teacher role.

4.2.4.1. Age range

One antecedent that will have consequences is the age range of the current population of nurse teachers. Clifford et al (2001) note specifically that whilst there was an increase of young nurse teachers in 1998 the trend since 1995 has overall indicated an increase in the age range of 41-50 year olds, who represent 49% of the

teaching workforce. The grey literature used for this review from one locality also demonstrated that the largest group of nurse and midwifery teachers were those above 40 to 55 years old (Harvey et al 1997). Harvey et al (1997) was also useful in that the same group of nurse and midwifery teachers were also very experienced in terms of academic and professional backgrounds, many holding a multiplicity of nursing, teaching and academic qualifications. This raises several issues. If the group is the most experienced in a nurse education department, it may then follow that they are given additional role responsibilities. This may serve to increase stress and subsequent role dissatisfaction of nurse teachers (McPhail, 1997, Coad 1998). On the other hand, if nurses and midwives are not actively recruited, who then undertakes these responsibilities as they retire or chose to leave.

4.2.4.2. Gender issues

A further antecedent that has far-reaching consequences for nurse teachers is the issue of gender (Figure 4.1). Arguably, the issue of gender has always existed for nurses and nurse teachers but it is worth noting in the context of this review. The UKCC (1998) noted that in a predominantly 90% female occupation, such as nursing, the division of labour and their subsequent professional development may be overtly or covertly curtailed at any level. Thus, a gender dichotomy exists in nursing at all levels where, although the number of men is smaller in terms of entry numbers, as a group they rise to senior positions in the profession more rapidly (Cyr 1992, Ratcliffe 1996). Males may be found in larger numbers in senior positions of management and / or education as nurse teachers. The updated Bett Report (Select

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Committee on Education and Employment, 2001) highlights the increasing issues of inequalities at all levels of recruitment, promotions, teaching posts and pay awards between female and male lecturers in higher education. In 1999, Hodges noted that in the life sciences (where she included nursing) that women make up 61% of the undergraduates, but only 15% end up as senior lecturers and only 7% become professors. Such antecedents are thus relevant to the issue of being a 'female' nurse lecturer in higher education. For example; in the future it may be the male nurse who is more 'attracted' to a career in HEIs (given the status and academic culture), whereas female nurses may feel the risk of leaving the NHS is too great and academic pressures too many to embark on a such a career.

4.2.4.3. Teaching responsibilities

Previous literature relating to historical development and teaching responsibilities were outlined Chapters 2 and 3, but the consequences of teaching as a lecturer in an HEI is still to be fully realised for nurse teachers (Barton 1998, Day et al 1998 Clifford et al 2001). It is these developments that will also have an impact on nurse lecturers' responsibilities (Figure 4.1). One example of this is the level of teaching that was expected. Prior to nurse education entering into higher education institutions the levels of attainment were largely up to diploma (Level 2) both in pre and post registration courses. In higher education institutions expected delivery encompasses diploma (Level 2), degree (Level 3) and masters (Level 4) levels. This means that the nurse lecturers will be expected to deliver a wider range of activities both in terms of planning and implementing curriculum. Consequently, as nurs

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4.2.5. Identify related concepts

A review of the literature indicated that there is a multiplicity of related concepts with respect to the nurse teacher (Figure 4.1). Despite the complexities in the literature of identifying common role attributes of nurse teachers, several key references were used to isolate re-occurring themes in order to help develop consensus for this review and are presented in Table 4.8. Some of these issues were highlighted previously in Chapter 3 but are outlined in the framework as follows:

- Classroom Role
- Student Issues
- Clinical Role
- Personal Development
- Administration
- Curriculum Development

Table 4.8. The range of related concepts to that of nurse teacher

Classroom Role	**Student Issues**
Macro and micro levels of learning Lecturing Tutorials Small group teaching Experiential learning Computer assisted learning and informatics Audio-visual aids Distance and open learning Skills based learning and competencies	Student/ teacher relationships such as counsellor, caring, need, responsibility, attitudes and personality attributes Accessibility Monitoring, Assessment and evaluation Trouble-shooting Discipline Placements
Clinical Role	***Personal Development***
Theory/Practice Links and partnerships Practice teaching Clinical settings Clinical Credibility	Undertaking of courses Research Activities Promotion / staff hierarchy/ management Experience Gender Staff relationships
Administration	**Curriculum Development**
Meetings Time Typing /Letter writing	Curriculum activities including philosophy, planning, change and innovation, delivery, assessment and evaluation Influences upon the curriculum such as tradition versus health policy and societal change. Subject based teaching such as physiology, psychology, sociology and research Specialist based teaching of nursing such adult based nursing, child health, mental health and learning disabilities.

Drawn from Quinn (1988), Kenworthy and Nicklin (1989), Buttigieg (1990), Jeffree (1991), Gerrish (1992), Clifford (1992, 1993a, 1993b, 1995a, 1995b, 1996a, 1996b and 1999), Coad (1994), Davies et al (1996), Camiah (1996), Brown et al (1998), Luker et al (1993, 1996), Carlisle et al (1996, 1997), Evers (2001) and Clifford et al (2001).

4.2.6. Identify a model case of the concept, if appropriate

Rodgers (1989) advocates the use of a real life example, if appropriate to demonstrate a model case related to the concept undergoing analysis. It is acknowledged that the role of a nurse teacher is very 'context bound' and selecting an example could be limiting to nurse teachers as a group. This view reflects that suggested by Hupcey et al (1996) in a critique of model cases within concept analysis work. It was felt, however, that there was enough literature to demonstrate a model case of a 'typical' current nurse lecturer as outlined Figure 4.2.

Figure 4.2. Case Study

Mary was a Ward Sister on a General Medical Ward. Before taking up her Ward Sister post she studied for a Diploma in Nursing, which she successfully obtained. Three years after commencing the post as Ward Sister she registered for a two year part-time Degree in Nursing.

After five years in post (2nd and final year of her degree) she was advised to take up a position of *Unqualified Clinical Nurse Teacher* (Grade 1) in a local School of Nursing. She enjoyed teaching and felt that this would be a useful career development. She worked as an Unqualified Clinical Nurse Teacher linking clinically to her specialist area of medicine.

After completion of her degree, she entered a teacher preparation course, after which she returned to the newly amalgamated College of Nursing as a Registered Nurse Tutor (Grade 2) to teach the 'new' Project 2000 Diploma course. The college had been formed from the merger of two Schools of Nursing.

After two years in the college discussions about the merger of nurse training into higher education began and she experienced her second educational merger, this time into the designated local university.

She was given a new title and contract - that of Senior Lecturer in School of Health within the faculty with the specific responsibility of delivering the adult branch on the Pre-Registration Diploma/Degree. Mary was given module lead for three modules including 'Introduction to Nursing', 'Medical Nursing' and 'Professional Development'.

In the role, Mary was expected to teach, organise modules and supervise a range of students including marking their work. She also had associated administration /managerial duties, including meetings; was expected to take on an active clinical link role and was asked to consider the undertaking of a Masters degree including research work.

4.3. Summary

This chapter has sought to 'build up' an evolutionary picture of the nurse teacher who was a person who developed skills in practice and entered into a career of nurse education into a school or college of nursing within the NHS as an experienced, senior nurse. The process of undertaking a concept analysis has shown that the concepts of 'nurse teacher' and/or 'nurse lecturer' are complex, multifaceted and are used implicitly in much of the existing literature. Furthermore, it has been noted that a change of title from that of 'nurse tutor to that of nurse lecturer' could impact on the expected role attributes. An attempt to demonstrate this change was outlined in the case study approach.

What the concept analysis has demonstrated is that the nurse lecturer role in HEIs needs to be clearly defined. Whilst there are clear antecedents to the role and some commonalties in the range of concepts used in the literature, there was a lack of consensus relating to actual definition and parameters of the nurse teacher role. This can also be linked to the lack of common understanding about accepted attributes (what nurse teachers actually do and do not do). What is worrying is that if, as suggested, the role of the nurse teacher is not clear, then as the group evolve in their role as lecturers in HEIs 'role confusion' could subsequently occur. Arguably, vulnerability of that group is also worrying. Studies which seek to define the role of the nurse lecturer in higher education will, therefore, not only be of interest but will be essential information for role development.

Chapter 5

The impact on the lecturer of nursing of the merger of nursing education into higher education as a cultural event

5.1. Introduction

To date this review has highlighted specific issues relating to the history of nurse education and the evolution of the nurse teacher role. The concept analysis revealed that the concept of a 'nurse teacher' is complex and that, whilst there are accepted antecedents to date, there is a lack of consensus about the actual role attributes. What has not been addressed in the review is the impact on the role of nurse teachers as a consequence of the merger of nurse education from colleges of nursing in the NHS into HEIs.

The key to the impact on role change lies with a broad recognition that the organisational culture of the NHS differs from that in a HEI. The merger into higher education may be perceived, therefore, as a 'cultural event', which could have an immense effect on the role of nurse teachers in the future. In order to understand the meaning of 'organisational culture' it is useful to explore a variety of ethnographic perspectives.

5.2. The meaning of 'organisational culture'

The original and central domains of studying culture lie in the eighteenth century when anthropologists' work came to the forefront as a distinct social science (Sackmann 1991). Hofstede (1980) noted that confusion occurs and that since the early times of studying culture, which date back to 1690, the boundaries between cultural investigations were so blurred that by the eighteenth century each social science group interpreted them differently.

This period denoted by Denzin & Lincoln (1998 pp18) as 'blurred genres' was in part due to the different contexts in which the varied social scientists operated and thus different assumptions occur. Sackmann (1991) suggests that at this time there were two broad aspects to the term culture. One refers to the complex broad whole of where everything is studied such as a tribe, social group or organisation. The second use refers to the specific aspects of the components of the culture such as the artefacts, rituals, customs, knowledge, beliefs, ideas or symbols (Sackmann 1991).

The 1960s saw the origins of a movement by social scientists and humanities to use the term 'organisational culture'. Although Schein (1986) purported that whilst there was no agreement on the meaning of this (including 250 definitions of the term) organisational culture was gradually established as an area of study. Currently, Sackmann (1991) suggests that three broad perspectives can be differentiated in the managerial literature, which are relevant to the context of this review. They include:

1. A holistic perspective
2. A variable perspective
3. A cognitive perspective

5.2.1. The Holistic Perspective

Sackmann (1991) notes that the holistic perspective draws upon and emerges from the work by anthropologists such as Benedict (1934) and Kroeber and Kluckhorn (1952) who integrate cognitive, emotive, behavioural, and artifactual aspects of culture as one unified whole. Within this perspective culture is defined as the ways of thinking, feeling and reacting to situations which occur in the distinct human group of the specific organisation. Handy (1993) usefully summarises the meaning of the holistic perspective. He suggests that it may be described as a general constellation of beliefs, morals, customs, value systems, behavioural norms and ways of doing work that is unique to each organisation. This sets the pattern for the activities, actions, behaviour and emotions characterising life in any given organisation.

Denzin & Lincoln (1998) suggest that a holistic perspective of ethnography concerns all of the culture shared by a bounded group of individuals and it is therefore widely accepted in managerial literature. One use of this perspective is that it captures the multifaceted nature of culture, which is helpful in anthropological or ethnographic studies. On the other hand, it is this breadth which ultimately can create problems for any ethnographic researcher who seeks to study culture from such a wide perspective. Sackmann (1991 pp17) suggests that one reason for this is that, although the researcher can integrate the historical development of an organisation with the dynamic evolutionary nature of the organisation, it is difficult to set boundaries to the study so creating 'a somewhat schizophrenic situation'. Therefore, many researchers using this perspective do so over a long period of time and use a variety of setting-specific data sources. They tend to focus investigations either on visible distinct manifestations, such as a hierarchy, or alternatively on the more intangible aspects of the cultural core, such as interviewing individuals about their beliefs on the distribution of power (King & Anderson 1995, Handy 1993).

5.2.2. The Variable Perspective

In the bulk of the relevant literature, the variable perspective focuses on the expressions of organisational culture that take the form of verbal and physical behaviours or practices, artefacts and their underlying meanings (Sackmann 1991). Anthropologists study such cultural patterns as symbols, which have shared meanings and in this way organisational culture is examined from the point of view

of expressive activities, behaviours and material artefacts within the organisation. The behaviour is predominately observed and self reported in order that the researcher captures the picture of rites and rituals or as Denzin & Lincoln (1998 pp20) state 'the way we do things here'. Examples of authors who have used this approach include Wilson (1992) who examined structural components of the organisation such as role, power distribution and tasks. It is from this viewpoint that interpretation occurs focusing specifically on the components of the organisation but seeking to analyse the chosen culture whether this is during times of stability or change or conflict (King & Anderson 1995, Hofstede 1991).

The process of 'deciphering' such cultural manifestations would appear very difficult. Sackmann (1991 pp20) refers to this as requiring 'guesswork' as the interpretation of various symbols by researchers with differing values and understanding can create errors of judgement. It therefore requires a skilled researcher who sets upon a journey viewing the culture from the insider view (or emic perspective) as opposed to the outsider view (or etic perspective) (Hammersley & Atkinson 1994, Morse 1994, Morse 1997).

5.2.3. A cognitive perspective

The cognitive perspective focuses on ideas, concepts, 'blueprints', beliefs, values or norms that are seen as the core of the complex phenomenon called 'culture' (Sackmann 1991 pp21). In anthropology and sociology these cognitive aspects are often described as organised knowledge or in other words the models and ideas

people have in their mind which they subsequently make sense of something, in order to interpret their own culture (Denzin & Lincoln 1998). The anthropologists, Schein's (1986) and Holden and Littlewood (1991), typify this perspective and views individuals not only for their own idea of 'normality' and patterns of behaviour but more importantly the way in which they operate when in a group (or organisational) situation. Thus, this approach can be used to study the set of basic assumptions that a given group has invented, discovered or learned to cope with over time in any organisation (Schein 1986).

Largely, this cultural perspective is widely utilised in the managerial and organisational literature using interview techniques (Schein 1986, Wilson 1992, Hofstede 1983, 1994 and Harrison et al, 1994). Although Sackmann (1991) used this perspective in a number of her studies she argues that it can be problematic as it entails much breadth (e.g. all the individuals in an organisation have to be interviewed) and rich depth (e.g. the individuals beliefs) can be subsequently lost. As a result, some authors have endeavored to overcome these problems suggesting a researcher uses a 'key individual' sample group (Sackmann 1991, Harrison et al 1994).

The difficulty in all three perspectives outlined is that they imply clear-cut beliefs that individuals work towards and that leadership is positively driven. In reality, Mabey and Mayon-White (1993) note that a degree of consensus in an organisation is actually rare as the aims may be in the interest of the individuals and not the

organisation. To overcome such challenges, Sackmann (1991 pp23-30) suggests that all the perspectives can be brought together to form a 'generic' construction of the social reality of the organisation and presents a simple, but practical model with three major considerations for researchers to reflect on prior to work in the field (Table 5.1).

Table 5.1. Major considerations for exploring the organisational culture

1. What are the components of the existing culture ?
2. What are the dimensions of the existing culture?
3. What are the (untested) assumptions of the existing culture ?

Sackmann's (1991) framework appears to be a useful, broad tool in order to gain understanding of a situation when, for example, a mismatch of aims (and expectations) occurs. Such a mismatch may be witnessed in an event such as a merger 'where one organisation moves into or takes over another' (Handy 1993 pp192). As the 'new' organisation takes over then there often heralds a change of culture, which may be subsequently accepted or rejected by the staff. As it is merger events that are important to this review it is pertinent to expand on some of the key literature.

5.3. Merger events

Several key research studies have examined merger events and the impact on the organisational culture including Hofstede (1991,1994), Pettigrew (1985), Kilcourse (1985) and Johnson (1987). Alternatively, other authors sought to analyse more specifically the impact on the staff of merger events (King & Anderson 1995, Mabey & Mayon-White 1993).

One specific example of organisational cultural work was undertaken by Hofstede (1980,1983,1991,1994). Over a period of several years Hofstede (1980,1983, 1991,1994) collected opinion surveys from employers of IBM in over forty different countries and from his analysis he developed an impressive analysis of cultural differences outlined in Table 5.2. Hofstede (1991,1994) notes that when two organisations or institutions with very different cultures and beliefs merge there are far-reaching consequences. He noted that different nationalities prefer different organisational cultures. This can be related to organisations in that some will prefer a specific style of management such as 'task orientated'. Thus, if a change occurs, such as a merger event, this can subsequently be counter-productive for that organisation. In this situation, the potential threats may be perceived to outweigh the positive benefits. Therefore, Hofstede (1991,1994) suggests that it is essential that in any merger event management responses are sensitive and rapid.

Table 5.2. Culture of Organisations (Adapted from Hofstede 1991, 1994)

1. **Power Distance** = The dimension of power between 'bosses and subordinates'. The larger the power distance the more power managers have and the more the subordinates expect to be told what to do. In organisations where there is small power distance there is more equality and greater consultation across all levels.

2. **Uncertainty avoidance** = This denotes the extent to which the members feel threatened by uncertain or unknown situations. In an organisation with strong uncertainty avoidance there are many precise rules whereas in organisation of weak uncertainty avoidance there are few rules, often flexible and a great deal of flexibility.

3. **Individualism versus collectivism** = Employees in an individualistic organisation are expected to act according to their own interest (as in 'I' and 'me' cultures) whereas in a collectivism system people are integrated into strong, cohesive groups like strong family links (as in 'we' or 'us').

4. **Masculinity and femininity** = Masculinity is concerned with ambition, material success and the desire to earn more whereas femininity relates to caring for others, negotiation, good inter-personal relationships and quality work-life.

Whilst Hofstede's (1980, 1983, 1991, 1994) work is useful in examining organisational mergers, it has limitations, as the feelings of staff are not specifically explored. This contrasts with other literature, including Mabey and Mayon-White (1993), Handy (1993) and King and Anderson (1995), who note that during any change in an organisation staff will use personal 'safety net' strategies. One 'safety net' is noted in staff communication or more specifically how they share information about the new organisation (Mabey and Mayon-White 1993). Mabey and Mayon-White (1993 pp92) suggest that sharing of information about the merger and new organisation, will help staff in the 'transition phase' and can be facilitated

through a series of 'action steps' to facilitate 'participation' and develop 'ownership'.

However, Mabey and Mayon-White (1993 pp93) acknowledge that such increased involvement is challenging and could even 'hinder' staff during the merger process. For example, in a situation where existing staff move towards and finally merge with another cultural system (and other staff) with a different set of beliefs and rules, new challenges undermine the safety net of the existing, accepted communication networks. This is witnessed, for example, if employees experience strategic manoeuvring such as intense negotiations about the proposed change and subsequent streamlining of staff (King and Anderson 1995). Even when staff feel involved in negotiations, King and Anderson (1995) note that decisions are frequently made by the more powerful personalities.

To overcome some of these challenges, Handy (1993) suggests that the individual will firstly enter a process of 'disengagement', or letting go of the past and striking out towards a new reality. A second stage commences, characterised by a phase of 'disorientation', or loss of familiar reference points and arousal of new requirements. Previous expectations of the organisation are disrupted and feelings such as frustration, role conflict, self-criticism are experienced. Subsequent role performance will be affected during this phase. Hardy and Conway (1988) previously noted that in order to overcome role anxiety, a pattern emerges whereby the majority of individuals accept the 'new' values and subsequently the

individual's adapt. In short, if an individual does not adapt they may not 'survive'. This would seem to have immense implications for change events such as a merger. Interestingly, Hardy and Conway (1988) and Handy (1993) suggest that in some cases assumptions held by the individual about the new organisation may completely change. Individuals who remain resistant to the change frequently leave and new personnel will join the organisation. As new staff evolve in their new roles they will subsequently alter the culture.

5.4. Cultural merger theory in the context of nurse education

From the perspective of nurse education there are few studies that examined the impact of the merger as a cultural event from educational provision in the NHS to that in higher education (Barton 1998, Day et al 1998). It is therefore pertinent to use the Sackmann (1991) framework as a platform for debate about the potential impact of the merger on nurse education.

5.4.1. What are the components of the existing culture?

There is much disagreement in the literature as to the meaning of cultural components. King and Anderson (1995 pp103) defined the components of culture as 'the climate of existing values, rituals, symbols, norms, beliefs and assumptions embraced by the participants'. Alternatively, Sackmann (1991 pp24) took a wider view relating components to 'the holistic ideologies or the basic philosophy, which constitute the set of norms for that organisation'.

Such issues can be applied to nurse education in the U.K. As outlined in Chapter 2, the majority of nurse training programmes in the U.K. had been organised since the beginning of the last century within schools of nursing placed in many cases within the NHS hospital environment. Even though each school of nursing would have had their own culture associated with history and local developments, nurse training (and education) programmes were largely organised in the traditional hierarchy of the NHS (Barton 1998). Most nurse teachers had trained in the NHS as service-led student nurses who, after qualifying, gained experienced through the hierarchical ranks of nursing. In a comprehensive study, Menzies (1993) explored hierarchical nursing systems in which she postulated that they were managed within a climate of 'socially structured dimensions'. By this notion, she suggested that nursing systems operated against a background of clear hierarchical structures and within a limiting organisational culture of multiple conflicts. As a consequence, decision-making is slow and responsibilities are often diffused from one grade of staff to another. Devitt (2002) noted that a career in nurse education, working in schools and colleges based in the NHS, undoubtedly served to reinforce this culture, largely due to the traditional inter-dependence of nurse education with the provision of a nursing service as outlined in Chapter 2 of this review.

As a result, the merger of nurse education into higher education generated a great deal of uncertainty about the expectations in the new organisational culture of HEIs as opposed to being part of the NHS organisational culture (Barton 1998). In a short editorial review, Draper (1996) noted that, whilst the merger into higher education

was critical for the nursing profession, it was also a critical point for the role of nurse teachers. He argued that few nurse teachers really understood what awaited them in the 'new' system of higher education.

As outlined elsewhere (Chapter 3; Section 3.4.4), Barton's (1998) study sought to investigate nurse and midwifery teachers' experience of the merger into higher education. It was undertaken in one college of nursing as the merger into a HEI was encountered and whilst it was limited in sample size the study raised issues pertaining to 'merger recovery' (Sackmann 1991). Barton (1998) found that as the sample group of nurse and midwifery teachers were 'recovering' from college of nursing mergers, they then fairly rapidly had to face further mergers into a very different system; that of the HEIs. Such 'cultural change upon cultural change' is clearly disruptive, increases anxiety and could affect what Hofstede (1991 pp120) terms as the 'uncertainty avoidance' of an organisation (where the members of a culture feel threatened by uncertain situations or the unknown occurring within the organisation). In terms of nurse teachers this could have immense impact on them, but unfortunately Barton (1998) did not seek to explore this aspect.

Several studies also highlighted that attempts at closer collaboration with higher education via the Project 2000 programme resulted in increased 'role stress' for nurse teachers (Jowett et al 1992, White et al 1993). There are many reasons for role stress. Specifically in relation to the culture of nurse education one important component must be where a traditional perspective ('this is the way we have always

performed nursing') is in direct conflict with an academic perspective ('using research and evidence to suggest ways of doing nursing'). As a consequence, Allan & Jolley (1987) suggest that an anti-academic culture could develop and the existence of this could be the basis of cultural rejection. Indeed, this was exemplified in several studies that highlighted a great deal of uncertainty about what the role expectations of nurse lecturers in higher educational institutions were (Kenrick 1993, Luker et al 1993,1996, Carlisle et al 1996, 1997 and Barton 1998).

Thus, the underpinning philosophy and reactions to the merger of nurse education into HEIs, as outlined, are important components of the culture of nurse education. Another consideration as suggested by Sackmann (1991) is the dimensions of the existing culture.

5.4.2. What are the dimensions of the existing culture?

The dimensions of a culture are influenced by the boundaries of the organisation, which will inevitably be affected by the change event (Sackmann 1991). Such boundaries include examples such as, the expertise and delineation of the staff, and organisational rules and structure (Sackmann 1991, Mabey & Mayon-White 1993). Changing such dimensions can, however, be challenging and may highlight the need to reconcile differing perspectives.

As indicated, the existing dimensions of the nursing college workforce were organised within clearly defined organisational structures with clear rules. Handy

(1993 pp134) noted that rules and regulations 'derive largely from a position of power' and are orchestrated to influence the workings of an organisation. Handy (1993 pp134) further suggests that these are 'formal' and are known to all (overt), whereas alternatively Hofstede (1994) notes that in some organisational cultures it is the informal, even unspoken, (covert) rules that have the greatest impact on controlling staff. In such a climate, well-delineated posts are also often witnessed (Handy 1993). This was found in the work of Luker et al (1993) and Clifford (1995a) where post delineation was clear and included:

- **Grade 1** – Unqualified Clinical nurse teachers.
- **Grade 2** – Qualified nurse teachers - the bulk of the teaching staff known as 'Nurse Tutors' or 'Clinical Nurse Teachers'.
- **Grade 3** – Senior Nurse Tutors or the bulk of nurse teachers.
- **Grade 4** – Senior Nurse Tutors responsible for organisation of department or speciality largely known as the Head of Department.
- **Grade 5** – Senior Nurse Tutors responsible for college organisation such as Assistant Director of Nursing Education.
- **Grade 6** – Director of Nursing Education

Thus, in the colleges of nursing, the division of labour operated within a 'hierarchical' cultural model (Handy 1993) or more commonly referred to as 'top down' management (Lewin 1951). This meant that the more senior staff (by rank or time served) had more administrative and managerial roles, whilst the 'junior' (Grade 1) nurse teachers were responsible for delivery of teaching. Thus, Sackmann

(1991 pp74) notes that in such a hierarchical system, rewards and perceived promotions are given to those who 'serve their time diligently'.

Subsequently, those individuals who are perceived to have 'made it' in terms of coveted roles and responsibilities are usually the more senior employees (or most long serving). Waiting and serving time is, therefore, part of the cultural expectations and anyone breaking out or being perceived to being promoted too early might be viewed with suspicion (Handy 1993, Sackmann 1991).

In contrast, the existing cultural dimensions of the university departments tended to have more 'flattened' structures in which all lecturers could be involved in teaching, administration and research (Brew 1995). As a consequence, nurse teachers entering into the new cultural dimensions of HEIs could face a very different management structure and responsibilities leading Barton (1998) to suggest that some nurse teachers might embrace the model whilst others would not.

Such 'cultural' differences were brought sharply into focus as nurse teachers expressed anxiety about role titles and seniority of posts (or the absence of) in higher education (Barton 1998). In 1988, Owen suggested that the merger of nurse education into higher education was perceived as an imposed decision and, therefore, potentially would create anxieties at all levels of staff. This was perpetuated in nurse education in that the discussions about the choice of higher education institution to be accepted for the college of nursing to merge into was

largely discussed and decided at a Regional Health Authority level (Chapter 2). In the early stages of discussions it was also reported that new nurse teacher contracts were negotiated with very little input from the actual nurse teachers in the colleges of nursing (RCN 1994). Moreover, as highlighted in Chapter 3, many reviews during the late 1980s and 1990s represented the feelings of concerns asking 'Who will lead the new faculties?' and 'What will nurse teachers do in higher education? (Owen 1988, Akinsanya 1990, Draper 1996, Lee 1996, RCN 1997, Miers 1997, Brown et al 1998, Rodriguez & Goorapah 1998, Ioaniddes 1999, Humphries et al 2000, Murphy 2000, and Smith and Gray 2001). Draper (1996) succinctly suggests therefore, that as a result, anxiety was high and would make the transition from nurse tutor to nurse lecturer even more difficult.

5.4.3. What are the (untested) assumptions of the existing culture?

In addition to the conceptual confusion about the components and dimensions of culture, Sackmann (1991 pp26) states that 'untested assumptions exist about certain characteristics of culture'. The meaning of untested assumptions are based on managerial or personnel assumptions about the organisation. They are frequently unclear beliefs about the future of the organisation and so are not evident until a cultural change event occurs. One untested assumption is the notion that nurse education would be better served by entering into a higher education institution. Whilst some issues were introduced previously, it is relevant to develop the discussion about the context of HEIs in the U.K. prior to analysis of this assumption.

5.4.3.1. The Context of Higher Education in the U.K.

In the immediate post war period universities in the U.K. were essentially elitist institutions with only 50,000 students across England, Scotland and Wales (Miller 1995). There existed other technical institutions either functioning as colleges or polytechnics, which largely awarded diplomas and some degrees. The 1950s and 1960s saw an expansion in the student numbers and by 1970 there were 443,000 students pursuing a degree (or equivalent) course in universities, colleges of education (previously known as the teacher training colleges) or polytechnics in the U.K. (Miller 1995).

In part, some of the expansion was fuelled by The Robbins Report (1963), which was a key educational document that legitimised a pattern of expansion founded on the grounds of both demand and needs of the U.K. economy. In addition, in 1964 the labour government under the leadership of Harold Wilson, established 29 polytechnics, a large proportion being formed out of colleges of education mergers. Robinson (1968) notes that the government hoped that such a move would introduce a tier of education that would be cheaper than the universities and more amenable to public needs such as industry, science and commerce.

Miller (1995) suggests that here began the 'binary principle', as introduced previously (Chapter 2; Section 2.6.4), where in the U.K. there are two systems of higher education, one system being autonomous (the traditional 'red' brick or universities) and the other being public-controlled (the 'new' colleges and

polytechnics). Thus, with the support of the government at this time the aim was to develop the latter more rapidly than the first to meet the growing demands of individuals wanting higher education, particularly related to their work base (Brew 1995).

From the 1970s, Robinson (1968) and Miller (1995), report that expansion of the British higher education institutions did not keep pace with other industrialised nations. This was 'dramatically accelerated by The Thatcher government' and as a result traditional university funding was severely 'cut back' in 1981 (Miller pp15). Miller (1995) gives a useful account of these cutbacks, suggesting that the aim of the process was to curtail the traditional universities' dependence on government funding and encourage sources of financial support such as monies received through research activities.

The 1988 Education Reform Act (Department of Education DoE 1988) was to redefine the organisation of both the 'new' and 'traditional' institutes of higher education. The universities, polytechnics and colleges of higher education were removed from local authority control and were given control of their own budget, including staffing under the control of the University Funding Council (UFC). However, the structure was divided as universities had one council whilst polytechnics and colleges had another. Miller (1995) notes that these measures largely gave the polytechnics and colleges a more strategic power base but it was not until 1991 that true change was witnessed for all higher education institutions.

This came with the publication of The White Paper Higher Education: A New Framework (DoEdSc 1991), which stressed the need for greater competition of student numbers and research funding, and a variety of key documents published by the Department of Education (DoEd. 1991,1993), which recommended new structures of organisation. Both created the opportunity for the following arrangements:-

- Abolition of the universities funding council of the universities, polytechnics and colleges and their replacement with a single funding council.

- The creation of separate higher education funding councils within England, Scotland and Wales to distribute funding for research and teaching.

- The extension of the title 'university' and of degree awarding powers, to those polytechnics and other suitable institutions which wished to use them.

- New arrangements for quality assurance and quality audit of teaching and research which would become more common across all the HEIs.

(Adapted from DoEdSc 1991and DoEd. 1991, 1993)

As a result, vast changes were witnessed in the higher education systems (Miller 1995). Most significantly, was the opportunity (criteria based) for polytechnics to form 'new' universities. Brew (1995) states that all such institutions in the U.K. subsequently enjoyed the title of 'University'. As a consequence of the removal of the binary line, the concept of what a university entailed diversified; some felt this was a positive evolution, whilst others felt that this devalued the nature of degree status (Brew 1995). Although in regulatory terms there was one University stream

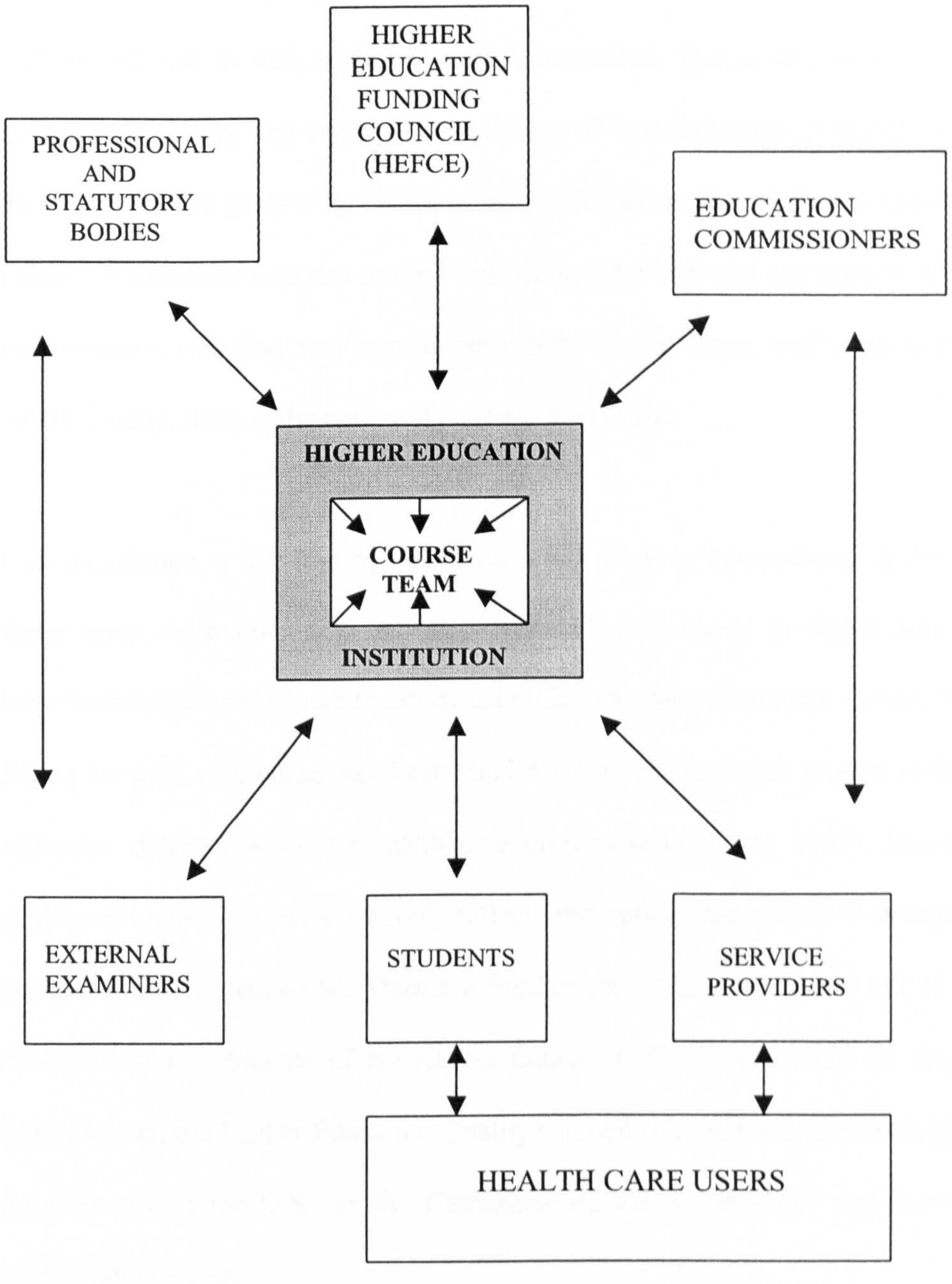
there was (and is) a tendency to use terms associated with two streams known as old, traditional or red brick as opposed to new universities. Turvey (1999) notes that such distinction only serves to create a world of 'elitist mono-cultures' where one steam of university is viewed more favourably than another.

In summary, the 'new' university culture gave rise to opportunities to meeting the needs of rising numbers of students. This had particular relevance for nursing as a practice discipline in which many colleges of nursing had worked in collaboration with polytechnics to develop nurse education. Consequently, a number of colleges of nursing merged with the 'new' universities and arguably this changed the university structure, both in terms of staff and the student population (Miers 1997).

5.4.3.2. Nurse education in HEIs

As discussed elsewhere (Chapter 2; Section 2.8.1), The Fitness for Practice report (UKCC 1999), identified the uniqueness of nursing curricular, but highlighted the problem between what was envisaged to what has been delivered. This report also highlighted the challenges of delivering health care programmes given the contentious nature of the stakeholders involved (Figure 5.1). The report also emphasises that at the interface of nursing education delivery there is a constant balancing of competing priorities of teaching, research, and clinical placements. Whilst HEIs were thought to help develop student nurses' academic ability further and thus give greater recognition for nursing, Miers (1997) notes that, in reality, this was still an untested assumption.

Figure 5.1. Current stakeholders in health care education



The notion that educational delivery in the curriculum will be 'better' in HEIs is difficult to examine as each curriculum, whilst established to meet a common goal, will be different in each higher education institution. This is due, in part, to the institutional politics and organisational history of that institution. Arguably, whilst there are common goals overall such as the development of 'safe practitioners' each university translates that aim in the local context. Educational and clinical practice environments will also vary considerably between university and location (Brew 1995). Finally, there is the notion of varying 'standards'.

One consolation is that nursing education is not alone in this problem. Indeed, for many years the maintenance and improvement of standards in higher education have been inextricably linked with quality (Church 1988, Harvey & Green, 1993). Rising to such challenges has been mused by all professional groups in higher education delivery including health care professionals (Cross 1995). Measuring quality of higher education delivery reflects the notion that quality is determined and measured as 'standards'. Thus, the Further and Higher Education Act of 1992 resulted in the setting up of the Higher Education Funding Council for England (HEFCE) and the Higher Education Quality Council (HEQC) was the starting point for a review of the U.K. by the Committee of Vice-Chancellors and Principals (CVCP) with HEQC.

Amongst a range of directives they sought to:

- Identify, make explicit and take account of existing understanding and approaches to academic standards.
- Test support for a clearer articulation of standards in the light of diversity, scarce resources, international dimensions, stakeholder concerns and changing expectations of graduates for the next century.

(Adapted from HEQC 1995)

The Quality Assurance standards of each faculty or school (and their relevant courses) are under scrutiny by a body of Quality Assurance reviewers using a scoring system for a variety of elements such as teaching and learning (maximum score being 24). However, if quality is to be measured and construed in terms of this body, French (1992) and Callery (2000) ask how objective are such reviews? Furthermore, in nurse education at the time of the merger such exercises were uncharted territory. This would seem to have had major challenges for nurse teachers delivering nursing programmes, but as Callery (2000) also notes parallels can be drawn from other disciplines such as teaching, that made an earlier transition into HE.

5.4.3.3. Nursing theory – practice interface

One other untested assumption in nurse education culture is the relationship between balancing the theoretical basis of nursing with the practical elements of the curriculum and the role of nurse teachers at the interface of this role. Briefly, in relation to nursing theory there have been many attempts in the literature to analyse

and define what this means. Nursing theory is generally interpreted as what is planned in the curriculum, what is taught in the classroom, any underpinning research findings and the knowledge gained from accessible material such as books (Stevens 1984, Quinn 1988, Meleis 1991, Chinn & Kramer 1995). Alternatively, practice is perceived as working in the clinical field (Meleis 1991, Chinn & Kramer 1995). A wealth of literature demonstrates that the relationship between nursing theory and nursing practice is complex (Meleis 1991, Walker & Avant 1995, Chinn & Kramer 1995) and that in nursing education a 'theory–practice gap' exists (McCaugherty 1991).

The 'bridging' of theory and practice of nursing through nurse education initiatives has always been an untested dimension of the culture. One prime example is the clinical link role, outlined in Chapter 3, which nurse teachers had previously undertaken as part of the 'culture' of their role in nurse education (Buttigieg 1990, Clifford 1995a, Luker et al 1993, Carlisle 1996). Previously, in colleges of nursing, nurse 'teachers' were expected to maintain a teaching link with the clinical areas in order to bridge the gap between theory and practice of nursing. Published reports therefore indicated that even before the merger into higher education, a 'theory-practice gap' existed and that this role has always been problematic for nurse teachers (Clifford 1995a, Luker et al 1993). However, following the amalgamations of smaller colleges of nursing to larger ones and finally the merger into higher education, clinical staff witnessed change in the clinical role of the nurse teacher (Barton 1998, ENB 1998b, Evers 2001, Clifford et al 2001).

One example is that in most centres previously nurse teachers were very much 'on site', as the colleges of nursing were part of the NHS and were traditionally situated on the hospital sites. Grey literature used in Chapter 2 highlighted that delivery of nursing education in some university centres had been placed geographically away from the clinical site and in a minority of cases this was several miles from the hospital base over a range of multiple sites. Other university centres had fought hard to ensure that a base was maintained on the hospital sites, although this also was challenged in some cases. Arguably, some nurse teachers may not currently be as readily accessible and it may be the case that the perceived gap between education and practice is wider than ever. Thus, for nurse teachers it may be that the gap between the academic and clinical components of their role, are subsequently harder to deliver. However, to date there is no substantive investigations that have analysed what clinical nurses feel about the educational change and the impact of this on relationships with nurse teachers.

At the time of the merger of nursing colleges into higher education institution a staff surplus situation was identified (Cox 1993). Thus the colleges of nursing had to streamline their workforce. During this process, the ENB (1998a) also reported that student numbers were falling and that less recruitment of nurse teachers was occurring whilst retention policies had not been fully developed. However, interestingly since that time student numbers have rapidly risen, but across the U.K. there has remained a limited recruitment and retention strategy of nurse lecturers in HEIs (Evers 2001). As outlined elsewhere in the review, the consequences are that

there are reduced numbers of nurse teachers. Evers (2001) highlights that nurse teachers have become increasingly frustrated in attempting to deliver high quality, up to date education in a changing environment. Having less nurse teachers, therefore, with larger groups to deliver to, may also mean that that the perceived 'nursing theory / practice gap' has widened and may continue to do so despite new educational innovations (UKCC 1999).

5.5. Summary

In summary, this chapter has sought to draw on the previous chapters in order to explore the merger into higher education as a cultural change event. No previous studies were found that used an organisational cultural framework in nurse education. Models of organisational cultural theory reviewed were found to be useful, but were often contradicted by the breadth of philosophies, ideas, values or norms that underpin the work. However, the use of Sackmann's (1991) model was useful as a framework to set the scene about nurse education from a cultural perspective and appears a useful tool to underpin the study reported here.

It is clear from using Sackmann's (1991) framework, that the reality of several educational changes occurring sequentially, such as the merger of smaller colleges to larger colleges followed by the transference of nurse teachers into HEIs, is likely to have effect on the nurse teacher role. Moreover, the NHS colleges merged into HEIs at a time when both education and the health service were affected by the changing policies and competing priorities of resource allocation. Nurse teachers are at the crossroads of cultural change and yet they are expected to continue to deliver a quality educational service. It is clear that the pressures of change may affect individual nurse teachers and could result in increased role conflict and subsequent stress. The test for nurse teachers will be how they cope with the change and the adaptation strategies that they employ.

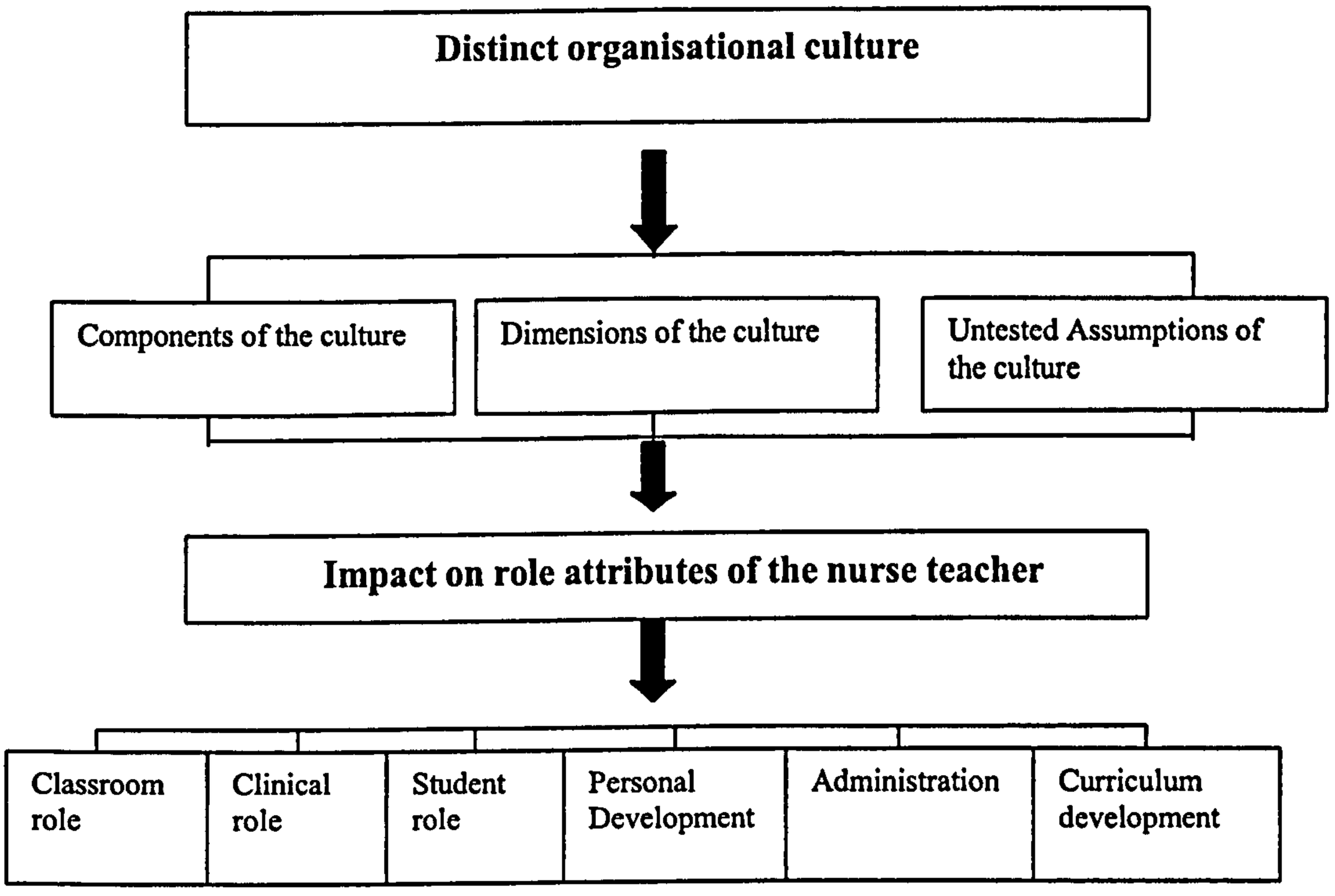
5.6. Summary of the literature review

In final summary, this review has highlighted the key issues that have precipitated the current change in nurse education. To date, studies undertaken on the nurse teachers' role have largely focused on individual nurse teacher clinical credibility, competence and the global context of how they link nursing theory to practice (Crawshaw 1977, Sheahan 1981, Jones 1985, Nolan 1987, Crotty 1993, Baillie 1994, Carlisle 1996,1997, Clifford 1995a,1995b,1996a,1996b and Luker et al 1993, 1996). However, despite wide recognition that the nurse teacher role is 'complex and multifaceted' it has never clearly been defined so role attributes are lacking (Clifford 1995a, ENB 1998b). This has implications for new roles of 'lecturers of nursing'.

The concept analysis of 'nurse teacher', 'nurse tutor' and 'nurse lecturer' indicates that, whilst all the terms are used interchangeably, none are fully understood. Arguably, as a group with an unclear title and role, nurse teachers may, therefore, be very 'vulnerable' (Devitt 2002). It may be that there are little or no differences in the expectation of the role of 'teacher' in comparison to that of a 'lecturer'. However, this is a supposition as only a few substantive research studies were found that had explored the concept of the nurse lecturer role in HEIs (Barton 1998, ENB 1998b, Evers 2001, Clifford et al 2001).

The principles of organisational cultural theory were outlined in the review including the work of Hofstede (1980, 1983, 1991, 1994) and Handy (1993), but specifically the 'cultural merger' model suggested by Sackmann (1991). Using the theoretical underpinning of Sackmann's (1991) work, demonstrated that any organisation will have its own distinct cultural components, dimensions and untested assumptions. Each of these will inevitably have an immense impact on the role, in this case nurse teachers. The principles of this framework would seem useful to underpin the study reported here as no previous studies in nurse education were found that utilised an organisational cultural theory as nurse teachers evolve into lecturers in nursing within HEIs. The overall theoretical framework that emerged from the literature reviewed is presented diagrammatically in Figure 5.2.

Figure 5.2. The Theoretical Framework identified from the literature



In conclusion, the literature reviewed has raised issues about the origins of nurse education and the nurse teacher role. Specifically there was only one study by Barton (1998), who studied the impact of the merger as a process, from when the nurse teacher worked in a college of nursing in the NHS through the merger transition to evolve as lecturers of nursing. This event marked immense change for nurse teachers as a group and would seem to be essential information if the nurse teacher role is to be fully understood. Moreover, this information is vital as nurse teachers find their place within the current political arenas occurring in both higher education and the NHS. It will not only be of interest to nursing today but it could help those planning health care education consider optimal ways of planning nurse education on the future.

Chapter 6

Methodology and Data Analysis

6.1. Introduction

The aim of the longitudinal study reported here was to explore perceptions of the nurse teacher role as a result of nurse education transferring from colleges in the NHS into HEIs. This chapter will give a rationale for the research approach used and discuss the methodological underpinnings of the study.

6.2. Research Design

The research design is the platform from which the researcher explores new knowledge to better describe and understand phenomena, and clarify plausible explanations (Talbot 1995). In this way it is the 'backbone' of the study and determines how the study is organised, and how data is collected and analysed.

6.2.1. Aims of the investigation

The aims of the study reported were to:

(i) Explore perceptions of the nurse teachers role as they move from working as 'nurse teachers' in colleges of nursing in the NHS to working as 'nurse lecturers' in HEIs.

(ii) Explore the impact on the role attributes of nurse lecturers as they develop their new roles in higher education from both an individual (micro) level and the wider organisational culture (macro) level.

(iii) Explore the perceptions of clinical nurses in relation to the nurse lecturers' role as a result of nurse education transferring into higher education.

(iv) Make recommendations about the nurse lecturer role that may be used to understand the role more clearly.

The overall research design was an exploratory study, using the principles of ethnographic research. In brief this included:

6.2.1.1. Stage 1

- A pilot study which involved a series of semi-structured interviews with two nurse teachers, two students, two clinical nurses and one university lecturer prior to the merger of nursing colleges in the NHS into higher education.

6.2.1.2. Stage 2

- In-depth exploratory interviews of a group of 15 nurse teachers on three occasions over 15 months (x 45 interviews) as follows:

Stage 2a: Three months prior to the merger into higher education when the nurse teachers were employed within one college of nursing in the NHS.

Stage 2b: At the 'merger point' when staff from one college of nursing in the NHS transferred into one HEI.

Stage 2c: Twelve months after the merger into one HEI had occurred

6.2.1.3. Stage 3

- Interviews with a group of 20 clinical nurses one year after the merger of nurse education from nursing colleges in the NHS into higher education.

6.2.1.4. Stage 4

- Questionnaire designed from Stages 2 and 3 involving two stages:

Stage 4a: Pre-test of the questionnaire

Stage 4b: Survey of nurse lecturers (n=140) in two HEIs, one year after the merger of nursing colleges in the NHS into higher education.

6.3. Methodological considerations

Talbot (1995) suggests that exploratory research should be conducted when the literature has revealed little substantial evidence about the phenomenon being explored. The literature indicated that little was known about the perceptions of the nurse teacher role as it evolved in HEIs. Consequently, it was decided that the most appropriate approach would draw upon exploratory methods as the researcher wished to explore perceptions of experiences and feelings over a period of time (Denzin and Lincoln 1998). In order to achieve the aims of the study, at Stage 2, a longitudinal framework was adopted as this represented a time in which nurse teachers worked in the NHS, immediately after the merger of colleges of nursing into higher education and during the first year of transition.

Historically, medicine and health care have been largely dominated by quantitative or experimental approaches to research, defined as the systematic collection of numerical information usually within controlled conditions using deductive processes of knowledge attainment (Streubert and Carpenter 1999). In this way it is the 'cause and effect' relationship between variables that drives the work and the ultimate choice of statistical analysis. In nursing, however, phenomena that are of interest, such as attitudes, opinions and perceptions, do not always lend themselves to experiments. Therefore, qualitative or non-experimental approaches may be preferred, which have long been associated with social sciences concerned with humanistic understanding (Robson 1993). Using the qualitative approach, data can be collected from within natural environments and includes the social, cultural,

experiences and feelings experienced by an individual in any given society (Streubert and Carpenter 1999). Through the collection of such data, Morse (1994) states that theories can be subsequently induced or alternatively hypotheses can be generated.

In the case of qualitative work, Denzin and Lincoln (1998) suggest that it is often criticised as being anecdotal, unreliable and invalid. Denzin and Lincoln (1998, Vol 2 pp7) add that qualitative research is often given the label of 'soft data' whereas quantitative work is considered to be 'hard data' and is subsequently viewed as more 'scientific'. They add that this endorses a view that carries with it 'negative inferences' for those undertaking qualitative projects.

From a methodological perspective, the collection of soft data such as feelings, beliefs and understanding of issues that affect people's lives was a key reason for utilising the approach chosen adopted in this study. Denzin and Lincoln (1998) therefore note that, in making the choice about preferred approaches, the researcher must clearly focus on the aims to decide the best approach to collect the data. Therefore, as the study reported here aimed to unravel questions pertaining to human perceptions it was most suited to the non-experimental approach (Clifford 1997b, Morse and Field 1996, Holloway and Wheeler 1996). More specifically, the principles of an ethnographic approach were chosen to help focus the direction of the work (Hammersley and Atkinson, 1995).

6.3.1. The Principles of Ethnography

The word, ethnography derives from Greek, meaning a description of people or more literally, 'a writing of culture' (Atkinson 1992 pp451). The foundations of ethnographic studies stem from cultural anthropology, where researchers such as Malinowski (1922) used the approach to discover the cultural rules, norms and values of groups of people, often in villages, that they studied. Malinowski (1922) lived with the people of the New Guinea Trobriand Islands for a total of two years in order to experience their daily life. His fundamental aim was as Malinowski (1922 pp25) stated, to 'grasp the native's point of view, his relation to life, to realise his vision of his world'.

Whilst this was the traditional origins of ethnography, other researchers used the same techniques to understand the cultural rules of individuals in urban settings. One classic example was undertaken by Whyte (1943), a sociologist, who described in detail the Italian urban subculture of one American city. Also based in an American city was the work of Spradley (1970), an eminent anthropologist, who studied homeless men. Thus, the ethnographer seeks to explain explicit aspects of a culture (what members are aware of, take for granted but can speak about) and tacit elements (outside of awareness and often unsaid). Consequently, an ethnographer learns from immersing themselves in the culture in order to be able to describe life in that community and discuss concepts such as their attitudes, knowledge and experiences (Spradley 1979, Roper and Shapira 2000, Taylor 2002). In this way

cultural events are worthy of study as they are holistic, contextual and reflexive and thus can add to the body of knowledge.

Ethnography was introduced in the field of nursing health care research through the work of Ragucci (1972), Brink (1982) and Leininger (1985). More recently, ethnographic research was used by nurse researchers, such as Holland (1993), who observed a group of nurses in order to study if ritual behaviour was prevalent in nursing practice and Griffiths (1998) who studied the use of humour in community mental health care settings. Therefore, ethnography is useful to nurses who have a holistic view of human beings and their focus of human response to health and illness.

However, since its first emergence in health care research, there has been an unresolved tension between what is considered 'the purist view of ethnography' and what is termed 'applied principles' (Streubert and Carpenter 1999). This can be traced back to the 'parent' discipline, of anthropology and more specifically to the data collection methods used. Traditionally, anthropologists considered themselves to be committed to working with empirically tested methods based on the rigorous collection of data through largely (and in some cases exclusively) observation (Spradley 1979). However, this is not always feasible. Therefore, in health care, including nursing, a diversification of data collection methods has been witnessed.

In many studies, interviewing was added to the traditional observation methods (Mueke 1994 from Morse 1994, Holloway and Wheeler 1996). Furthermore, whilst Leininger (1985) supports using observation and interviewing together as complementary data collection methods, she suggests that interviews should not be used in isolation if theory is to be truly developed. However, Morse (1994) argues this could be viewed as the 'purist' view of ethnography, a view that is acknowledged in the study reported here. It was thus decided that, whilst the principles of ethnography were essential to the underpinning beliefs of the work, the study reported here would adapt the data collection methods. Previous nursing research has successfully undertaken a similar approach (Morse 1994, Roper and Shapiro 1999).

In the study reported, a semi-structured interview schedule was used as the main form of data collection during Stages 1, 2 and 3. Observation was considered in the study reported but rejected for several reasons. Firstly, because researcher time to undertake observation in the field would have been limited. Secondly, observation would have been difficult because the nature of work undertaken by nurse teachers is commonly performed at an individual level (e.g. preparing lectures, administration, student support, meetings and research). These components of activity do not lend themselves easily to observation. In such cases in order to capture a representation of what is happening, Hammersley and Atkinson (1995) and Holliday (2002) both suggest that alternative methods, such as repeated interviews can be considered.

However, Hammersley and Atkinson (1995) note that one principle in any ethnographic study must be that the researcher should record findings that do not disturb the natural state. This was acknowledged in the study reported here as the natural state was the 'merger event', which was taking place irrespective of the investigation. Whilst there was little likelihood of disturbing the overall merger event, arguably, any of the interviews or questionnaire could have disturbed the natural state of the participants such as the impact of explaining their feelings. These aspects will be discussed further in Section 6.6.

6.3.2. Methodological triangulation

As outlined, it was decided that the best method to record the data was with a 'snapshot' interview approach before, during and after the merger of nurse education from the colleges of nursing in the NHS to HEIs. It was also proposed that a questionnaire would be used at the last stage (Stage 4) of the study to affirm preliminary findings. Although questionnaires are traditionally not used as data collection tools for ethnographic work, Silverman (1993) suggests that they can be a useful tool to support interview data, provided the interviews form the basis of the questionnaire. This is the case in the study reported, which uses exploratory interviews to 'build up' the picture for use of a descriptive survey in the form of a questionnaire (page 160). This approach is known as methodological triangulation and is commonly used in research. Indeed, Roper and Shapira (1999) used methodological triangulation using interviews and follow up questionnaires

sequentially in their ethnographic study of agitation in Alzheimer's patients as perceived by a group of nurses. It is worthy to outline this as an approach.

The word triangulation originates from navigational terminology and literally means to take on multiple methods to locate an unknown position accurately. Thus, researchers use triangulation to assure that a complete picture is presented (Streubert and Carpenter 1999). There are several types of triangulation, but originally, Denzin (1978) stated that there were four types of triangulation, which included:

1. Data triangulation: the use of a variety of data sources, although all have a similar focus such as 'space triangulation' where data is collected from multiple sites.

2. Investigator triangulation: the use of several different researchers or evaluators

3. Theory triangulation: the use of multiple perspectives to interpret a single set of data and thus create a framework for the study.

4. Methodological triangulation: the use of multiple methods to study a single problem. This may occur at the level of data collection or data design.

Since Denzin (1978) a further commonly used type of triangulation to emerge has also been 'analysis triangulation' which involves two or more approaches to the analysis of the same data (Streubert and Carpenter 1999). Thus, choice of type depends on the personal preference and suitability to the investigation.

Methodological triangulation was chosen in this study as it allowed for both qualitative and quantitative data to be collected in the same study. Streubert and Carpenter (1999 pp302) add that in methodological triangulation if one data collection is completed and the second commences thereafter this is termed 'sequential implementation'. This was the case in the study reported. In this way it is hoped that in this study the data collected will enable a rich, in-depth picture to emerge.

Triangulation is not without problems. With respect to methodological triangulation it can be time consuming and labour intensive. Holloway and Wheeler (1996) note that multiple methods can result in a multitude of findings. Therefore, instead of a rich picture being developed a confused account emerges. Although such considerations were noted, it was felt that in this study, that methodological triangulation would help to enhance the overall depth of the work. Streubert and Carpenter (1999) suggest that in order to overcome such issues the researcher must ensure that 'rigor' is seriously considered at each stage of data collection. In relation to this study this is discussed in Section 6.7.

At Stage 2 of the study, a longitudinal framework was adopted over 15 months, the context of which can be further outlined.

6.3.3. Longitudinal Framework

Oppenheim (1992 pp33) defines a longitudinal framework as 'taking repeated measures of the same respondents at several timed intervals over a long period of time'. In relation to the ethnographic principles outlined this seemed appropriate as the data could be collected at vital stages of the investigation which Denzin and Lincoln (1998) suggests ultimately enhances the richness of the study.

Leininger (1985) notes that when using the principles of ethnography over time a nurse researcher can truly develop relationships and in this way improve the quality of data collected. Furthermore, as a consequence of employing a longitudinal framework, Handy (1993) notes that organisational culture can be viewed in the long and short term, but it is in the long term that cultural change takes place, a factor that was seriously considered in this study.

Oppenheim (1992) notes that longitudinal studies can be prospective or retrospective. Prospective longitudinal studies often involve 'snapshot' approaches using one set of participants to collect data from, then returning at another point in time to undertake a 'follow up' study. In contrast, retrospective work often looks back at facts and events using defined, timed collection points to do this. In the study reported, a prospective longitudinal approach was adopted at Stage 2, three months before the merger into higher education when nurse teachers worked into one college of nursing in the NHS, at the merger into one HEI, and twelve months

following transition. This was felt to encapsulate, not only the perceptions about the nurse teacher role at one point during the 'merger event', but also over time.

The decision making process about the choice of the longitudinal approach was further facilitated by work undertaken by Goldstein (1979 from Oppenheim 1992), who suggests that decisions can be made using the categories in the model outlined in Table 6.1. In this study, factors noted above appear to fit in with category A with respect to the exploratory principles and that there was little known about the impact of the merger into HEIs on the nurse teachers' role.

Table 6.1. Decision-making in longitudinal designs

A. Little is known. The researcher cannot control the overall event as data collection takes place. Exploratory work.
B. Well-researched domain but the researcher has no power to influence events.
C. Little is known. The researcher can influence the event as data collection takes place. Exploratory work.
D. Well-researched domain. The researcher can influence events. Uses 'before and after' designs with measurable hypotheses.

Marsland (1999) notes several advantages of longitudinal frameworks. Firstly, they allow analysis of change at the individual (micro) as well as the aggregate (macro) level. In the study reported, the intention was to record perceptions of the nurse teacher role, whilst also exploring the wider cultural change of the organisational event on this role. Thus, analysis could take place at a micro and macro level. Secondly, Marsland (1999) suggests that if the researcher is looking back 'after the

fact' inaccuracies can occur. In the study reported, reduction of inaccuracies occurred through recording data as the 'merger events' were taking place as opposed to looking back 'after the fact'. The opportunity to collect data whilst it was occurring and fresh to the participants was felt to be essential. Oppenheim (1992) suggests that it is especially useful if the longitudinal study uses the same participants over a period of time as this can allow for greater precision of consistent data to be collected from a given number of respondents.

In this study, the same group of participants were used at Stage 2. At this longitudinal stage, data was collected at three strategic points as outlined, over a period of 15 months, from the same group of fifteen nurse teachers who had experienced the same merger event into the same university. The nurse teachers were 'related' in role and experiences within the same institutions. In this situation, Marsland (1999) notes that after the initial baseline interview the speed of collection will be greater as the participants have a greater awareness of what is expected from them and may be less anxious.

Utilising a longitudinal framework does not come without its challenges. Oppenheim (1992) outlines some common problems. Firstly, recruitment and retention of participants can be problematic. This is supported by the work of Smith (1999), who found that in a longitudinal survey of counselling in inflammatory bowel disease, some participants did not want to enter the study because of the commitment that this would entail whilst others chose to leave at a variety of stages

throughout. In this study, once recruitment had taken place no participant left during Stage 2. However, the group of nurse teachers involved at Stage 2 could have been a problem as there were several months between the first time of interview ('the base line'), the middle interview and the final interview. Marsland (1999) suggests that strategies to maintain co-operation are essential, discussed later (Section 6.6.1), but was facilitated using a 'snapshot' approach where different participants at Stages 1, 3 and 4 of the study were used.

Oppenheim (1992) notes that a further problem in a longitudinal survey is that bias can be high as relationships are built up, raising issues of reliability of findings. The risk of bias is a serious consideration in any project. A concern in this study was that during Stages 1, 2 and 3, the researcher performed all the interviews and was the 'inside researcher'. Whilst this will be discussed in Section 6.7, it is worthy to note that the researcher is a nurse teacher with a nursing background and was not only studying the merger, but was experiencing a 'merger event' first hand. Consequently, bias could have been very high. It is interesting that Spradley (1979) argues that in longitudinal ethnographic investigations bias is essential for the researcher to understand the full experience of the event. Leininger (1985) also notes that being the 'inside researcher' can be useful in nursing investigations as the nurse researcher is familiar with the terminology and any 'culture shock' experienced may be subsequently reduced.

Denzin and Lincoln (1998) notes that in longitudinal studies there can potentially be large amounts of data generated and consequently many variables to consider. Thus, analysis of the data may be affected as some issues can be represented superficially, whilst others are missed. As outlined, in this study during the fifteen-month time frame of Stage 2, 45 interviews were completed with 15 participants (see page 4). In addition to this, there were seven interviews from Stage 1, 20 interviews from Stage 3 and at the final stage, Stage 4, 140 questionnaires were distributed and 98 were completed and returned. Therefore, there were many variables to consider and a huge amount of data to handle. An attempt to reduce this was undertaken using the recommendation of a timed 'snapshot' approach in that, after each batch of interviews was performed, there followed a phase of analysis (Oppenheim 1993; pp170). In short, data was collected and analysed in small packages as part of the process, rather than one final set of analysis.

Oppenheim (1992) also notes that longitudinal surveys can be superficial in depth as potential participants are inevitably missed out. It should be noted that nurse teachers were not the only group affected by the merger into higher education. The existing university lecturers in HEIs who taught nursing subjects also experienced cultural changes as a result of nurse education transferring into their organisation (Chapter 5). Also, the status of groups associated with nurse teachers changed, one example being the students who may have different expectations of a university when compared to a college of nursing in the NHS. The groups associated with nurse teachers were interviewed at Stage 1, the pilot phase, which helped to focus

the research activity at Stage 1. It was, however, felt that to interview students and the existing university lecturers within the longitudinal framework would have done little to answer the key aim in this study i.e. the impact of the merger into higher education on one group of nurse teachers. Therefore, at Stage 2, it was decided that only nurse teachers would be interviewed who were transferring from a NHS college of nursing to a higher education institution. In order to overcome any superficiality, as noted by Oppenheim (1992), at Stage 3, it was decided that clinical staff would be interviewed. The exploratory interview data from both Stages 2 and 3 would then inform the questionnaire for use at Stage 4 with nurse lecturers only.

Overall, the methodological principles using the exploratory methods have been discussed in this section and were felt to be the most appropriate given that little was known about the perceptions of the nurse teacher role as it evolved in HEIs.

6.4. Location

The study was located at one college of nurse education (College A), three National Health Service (NHS) hospitals (Hospitals A,B and C) and three universities (University A,B and C) in England. A review of the location is essential and each is described below.

6.4.1. College A

College A was involved in Stages 1 and 2a of the study reported. It was managed by the NHS and was linked to hospitals A, B and C respectively in terms of provision of a range of educational programmes and clinical placement experience for students. During 1993, College A had emerged as a hybrid of three existing colleges of nursing (Colleges A1, A2 and A3 respectively) across the city where the study was located. Two of the colleges offered nursing courses (Colleges A1 and A2) and one was a midwifery college (A3). Each of the three colleges were inner city nurse or midwifery colleges serving hospitals which catered for patients from wide cultural and ethnic minority groups.

As outlined in Chapter 2 (Section 2.6.2) of the literature review, the publication of The White Paper Working for Patients (DoH 1989a) and Working Paper No 10 (DoH 1989d) resulted in new strategies for nurse education and training. As a result, the three colleges (A1, A2 and A3) had links to higher educational institutions across the city and academic accreditation was obtained via approval mechanisms in the higher education section. Each of the three colleges had experienced other amalgamations and at each merger this had meant a streamlining of educational staff and resources. The final merger announced by the Health Authority on the 5th July 1993 was that the three colleges had to merge into one (College A). This was to have the major implications for the staff as this was to be the final merger within the NHS before the proposed merger into higher education.

It was felt the formation of College A would result in 'a combining of teaching resources' and would meet perceived requirements that there would be 'fewer students required across the region' (Mallaber 1993). Implications for staff meant that firstly, a new organisational structure had to be devised which resulted in less senior managerial positions available. Consequently, new contracts of employment had to be negotiated as the new college (College A) was formed. As identified in Chapter 5, organisational change inevitably impacts on staff in the new organisation, a situation that increases staff anxiety. In this case, for example, the number and range of posts available increased such as anxiety, due to staff being concerned about their future role. Secondly, a new name for College A had to be decided. Change of organisational title can add to anxiety, as personal affiliations with the 'old' organisation have to be 'let go'. A name was finally chosen that was felt to represent the area and the main inner city where student nurse and midwifery training took place.

Partners in higher education had been formed before the amalgamation of College A. Previously two of the colleges (A2 and A3) had different higher educational partners to College A1. College A1 was linked to the traditional university of the city, whilst the other linked with the new university, which had previously been the polytechnic in the city. After the merger into College A, the transfer of nursing and midwifery education from the NHS to higher education' was imminent (Cox 1993). Therefore, in 1993, a series of discussions and meetings took place with representatives from College A with representatives from the Health Authority to

decide which institution had the most suitable package. In summary, the emergence of College A was fairly representative of relationships between NHS Trusts and HEIs across the UK at that time.

6.4.2. Hospitals A,B and C

Hospitals A, B and C were used to access the clinical staff sample at Stages 1 and 3 of the study reported. A key factor affecting choice was the geographical location of College A in relation to all the hospitals as they were readily accessible to the researcher across a defined inner city area in England. As a result of the sampling frame, hospitals were accessed which were associated with the nurse teacher group identified for this study. Therefore, each of the hospitals used were NHS Trusts serving the needs of adults (Hospital A), children (Hospital B) and mentally ill adults (Hospital C). The nurse teachers involved in this study had, in the main, worked as 'link teachers' in Hospitals A, B and C and each hospital provided placements for student nurses both undertaking pre and post registration. Thus, each hospital was connected to College A, and later University A, in terms of the purchaser - provider relationship, as highlighted in Chapter 2.

6.4.3. University A, B and C

Three universities (A, B and C) were utilised in the study at Stages 1, 2b and 2c and 4 of the study. Each of them had previously been a polytechnic, but as a result of the abolition of the binary line in 1992 (Chapter 5), each had each become a 'new' university. Each of the three universities was in a large inner-city town and offered

a wide range of technical and academic courses across their faculties, each being led by their own Dean. They each had a separate faculty for health and/or social sciences, which included nursing. Consequently, nurse teachers participating in the study had transferred from the local colleges of nursing within the NHS into one of the three universities.

University A was the main focus of the longitudinal study reported at Stages 1, 2a, 2b and 2c (Section 6.2 see page 160). In University A, there was a Faculty of Health that offered nursing programmes from Diploma up to Masters level in the faculty prior to the merger. For example, during 1993, 1,959 nurse and midwives had accessed the post-registration courses. The faculty of health had been re-organised in 1992 to produce a flat organisational profile with staff grouped in relatively small schools in order to reflect the academic and professional commitments. The Faculty infrastructure included;

Dean of faculty

Assistant Deans (Academic development and Quality, Learning resources, Staff development, Research and Consultancy)

Heads of Schools / Lecturers

Quality Assurance and monitoring system

Administrative Support

Learning Resources

Technical Support

Computing laboratories

Central systems for resource allocation and financial control

University A had also had links with one of the nursing colleges (College A2) since 1984 as part of the ENB pilot schemes and subsequently Project 2000 programme, and was responsible for the academic validation processes of the 437 nursing students on this course from College A2. Having established links with College A2, University A fully supported the policy of 'transferring the training of nurses and midwives from the health service to higher education' (Cox 1993). This provided a suitable location framework for the study reported and so became the location for Stages 1 and 2 of the study reported.

University B and C had similar infrastructures and histories as described above. University B was a polytechnic from 1969 and University C since 1987, prior to university status in 1992 as indicated. The colleges of nursing transferred into the respective universities to form faculties of health in 1995. Both University B and C delivered a wide range of pre-registration and post graduate nursing and midwifery programmes from Diploma to Doctorate level.

6.5. Sample Selection

A sampling frame must be decided in any project. Quantitative research usually involves a process of selecting a portion of the population to represent the entire population (Oppenheim 1992). Thus, sampling frames are often random and statistically calculated (Denzin and Lincoln 1998). However, in qualitative work this is not required as work is usually purposive and conceptualised using the literature and focus of the study as a means of framing the subject group (Miles and

Huberman 1994). As highlighted elsewhere (Section 6.3.2.), this study used methodological triangulation of interviews and questionnaire sequentially. Therefore, Streubert and Carpenter (1999) note that sampling choices do not need to be dictated by such issues, but rather can focus on purposeful, convenient samples of participants who are able to meet the study aims.

The sampling frame in the study reported was purposeful supporting the ethnographic principles underpinning the approach as outlined above (Spradley 1979, Streubert and Carpenter 1999). The participants were chosen for their suitability in that at each stage they were purposeful in order for the study aims to be met, and were convenient in that they were available to the researcher. Each sample at each stage of the study is described.

6.5.1. Sample A – Stage 1

Stage 1 was located in College A, Hospital A and University A. It consisted of a series of seven pilot interviews with two nurse teachers, two student nurses, two clinical nurses and one university lecturer. The selection of the group was purposeful as it drew together a selection of views of individuals who were, or had contact with, nurse teachers and were invited to undertake preliminary inquiry to develop the interview tool for the study. It was felt that such interviews would help determine the range of subjects (and groups) to be used at a later stage.

The two nurse teachers were both female, working in College A as 'Nurse Tutors' at the educational Grade 2, which at the time represented the bulk of the nurse teacher population as outlined previously (Chapter 3). The two student nurses were also female and had been drawn from a third year Diploma in Nursing cohort offered at College A. Both students were on a general nursing programme and had experienced clinical placements in Hospital A. The clinical nurses comprised of one female and one male from Hospital A. Both had been working as Registered General Nurses for a period of at least three years. As their wards were linked to College A, students were given clinical placements. Moreover, part of the two clinical nurses' role was to act as clinical supervisors to the students allocated to the ward. Finally, one female lecturer who had worked for University A as a Principal Lecturer was identified. She had worked for at least four years in University A after gaining considerable nursing and teaching expertise in the NHS education sector.

6.5.2. Sample B – Stage 2

From a population of 140 nurse teachers at College A, a potential sample of 20 male and female nurse teachers at Grade 2 were identified through a person independent of the college, choosing 20 names from the staff telephone list. Midwifery teachers (n=40) were excluded from the list, as the focus of the study was nurse teachers. The age range of the 20 nurse teachers sampled was 30 to 49 years, and included fifteen females and five males. All had worked in nurse education for at least two years.

The sampling frame of this study did not intend to target all nursing specialities that nurse teachers belong to, such as adult, child, mental health and learning disabilities, as the focus was on experience rather than subject speciality. However, the initial group approached did reflect professional diversity. Of this group of 20, five refused to participate including both nurse teachers from Learning Disabilities; they intended to leave nurse education on early retirement, voluntary redundancy packages or to seek alternative employment. As a result, this group indicated that they preferred not to participate in the study, as they would not be available for the longitudinal framework.

This left a total of 15 nurse teachers who anticipated transferring from College A to University A who were willing to become the 'key informants' of the longitudinal stage of the study (Crabtree and Miller 1992). This meant that they would be interviewed at three stages; those being Stages 2a, 2b and 2c. The sample group included eleven women and four men, some of which had worked in nurse education for up to fourteen years, with an age range of 32 to 49 years working in the specialities of adult, child and mental health as outlined in Table 6.2.

Table 6.2. Breakdown of the sample used from University A at Stage 2

Speciality	**Male/ female**	**Age range**	**Years in education**
Adult (10)	2 males 8 females	32 to 49 years	2 years to 14 years
Child (2)	2 females	40, 47 years	8,14 years
Mental Health (3)	2 males 1 female	39 to 49 years	4 to 14 years

6.5.3. Sample C – Stage 3

From the preliminary interviews at Stage 1 it was decided that at Stage 3, one year after the merger of nurse education into higher education, clinical nurses would be interviewed to elicit information about their experience of working with nurse lecturers in their new role. The clinical nurses sampled at Stage 3 were a purposeful, convenient sample of 20 qualified nurses who worked in adult settings (n=12 from Hospital A), paediatrics/child health (n= 5 from Hospital B) and mental health (n=3 from Hospital C). Forty names were given to the researcher via senior nurses at Hospital A, B and C. These nurses had all been qualified for at least two years and were clinical supervisors to student nurses undertaking various courses organised by initially College A and then University A. Of the 40 nurses approached, 20 expressed a willingness to participate in the interview. The final group included seventeen females and three males, with an age range of 24 to 41 years, within the nursing grades of D Staff nurses to G grade Ward Sisters/Charge Nurses.

6.5.4. Sample D – Stage 4

The nurse lecturers at Stage 4 were a purposive sample from University B and C, across the Midlands, in England. The universities were identified as supplying similar educational provision to University A and had undergone similar 'merger events'. Therefore, this sample provided the opportunity to explore views of similar nurse teachers in two other universities and thus verify previous data. Both

University B and C were asked to provide a sample of nurse lecturers who had worked in the NHS colleges of nursing and who had experienced the merger into higher education.

From a population of 142 nurse lecturers at University B and 42 at University C, a sample of 100 male and female nurse lecturers were sent the questionnaire at University B and 40 were sent at the request of University C (Total questionnaires sent = 140/ 98 return). This is illustrated below in Table 6.3 but is discussed further in Chapter 10 (Section 10.2).

Table 6.3. Breakdown of the sample responses from University B and C at Stage 4

Institution code	Number of staff	Total circulated	Total Returned	%
University B	142	100	74	74
University C	42	40	24	60
	184	**140**	**98**	**70**

In summary, the sampling frame, based on institutional provision, helped gain small but largely representative groups in all stages of the study. To reiterate, in the longitudinal stage of the study reported, none of the participants left during the two-year framework. The sampling frame was in keeping with ethnographic principles and the longitudinal framework meant a rich source of data was obtained from which research issues could be explained.

6.6. Data collection

A salient feature of any investigation is the method of data collection. Couchman and Dawson (1995) suggest that the structure and methods employed must be determined by the research aims. In the study reported, interviews were the main source of data collection at Stages 1, 2, and 3, followed by a questionnaire at Stage 4. Each will be outlined below.

6.6.1. Interviews

The principle methods of data collection at Stages 1, 2 and 3 were exploratory interviews. The purpose of the qualitative interviews was to record perceptions of the nurse teachers' role during the transition of nurse education transferring into HEIs. Spradley (1979, 1988) states that most commonly ethnographic researchers employ in-depth interviewing methods within the field so that they can gather the required information. In keeping with ethnographic principles, the interview technique should be flexible so that responses can be adapted, aspects which other methods may not be able to fully achieve (Oppenheim 1992).

Interviewing is a popular method of data collection. It takes many forms ranging through unstructured, semi-structured and structured formats (Burgess 1984). In this study, semi-structured interviews were used at Stages 1, 2 and 3 and were developed from the key literature reviewed and as a result of Stage 1, pilot interviews (Appendices 7, 8 and 9). Furthermore, specific discussion with 'key' experts and the project supervisor helped in phrasing the questions. Moreover,

using a semi-structured format allowed the interview to have some structure, but was flexible enough so that the interviewer could clarify the point or question being asked (Gorden 1975, Fetterman 1989). They were also felt to be less prone to misinterpretation by the participants, in contrast to an unstructured approach. This is supported by Fetterman (1989) who notes that the researcher can gain information that might otherwise be difficult, arguably impossible to obtain.

However, interview training should be considered when undertaking interviews. Spradley (1979) suggests that the interviewer must possess inter-personal qualities that will enable them to direct the interview event in a conversational manner without the participant feeling threatened. Spradley (1979) coins this as the 'explicit purpose'. The intended outcome of the interview is achieved without the participant being specifically aware of such an outcome. This requires considerable skill and has implications for interview training (Burgess 1984, Gorden 1975).

To address this, a period of training was undertaken whilst undertaking the Stage 1 pilot interviews. To assist training procedures, an independent researcher examined each of the seven interview transcripts and discussion took place pertaining to the data at each level of collection and interpretation of data. This was not only useful for the researcher's interviewer skills, but also helped develop data analysis skills. This was important for it meant that the researcher approached the main study with a much higher level of expertise in interviewing.

6.6.1.1. Interview Performance

No research method is flawless and several potential problems can be identified when using interviews. For example, Oppenheim (1992) points out that in using the exploratory semi-structured technique the interviewer must consider that their personality, age, skin colour and gender may work for or against the interaction process. As a consequence, the participant may be intimidated or feel awkward (Talbot 1995). On a similar point, Burns and Grove (1999) suggest that differing value systems are essential in health communications but can equally create problematic interpersonal behaviour. Furthermore, as highlighted previously (Section 6.3.3) participants at the longitudinal stage of Stage 2 had to be interviewed three times so co-operation was essential. These considerations were noted and during the interview the researcher aimed to accommodate them as discussed below:

6.6.1.2. Interview schedule

It is important to note that the design of the interview schedule must be considered carefully to ensure validity (Gorden 1975). Prior to Stage 1, a decision was made that the pilot interviews would help to 'trial run' the interview schedule (Appendix 7). Miles and Huberman (1994) support such a process in exploratory work as common threads to focus in the interview tool can be identified and thus superfluous data is reduced. Following the pilot work at Stage 1, two interview schedules were designed for the main study, one for the nurse teacher group at Stage 2 (Appendix 8) and one for the clinical nurses at Stage 3 (Appendix 9). As

noted earlier, at Stage 2, nurse lecturers were being interviewed at three predetermined points (2a, 2b and 2c), and the same schedule was used at each interview to ensure consistency. Different interview schedules were needed for nurse teachers and clinical nurses because the focus of information sought was different. For example, the nurse teachers undertake a different role to clinical nurses and each will perceive the nurse teacher role from their own perspective using their own particular terminology.

The schedule facilitated topic consistency and ensured that during each stage participants were asked the same questions in the same sequence. Such an approach allows participants to expand on specific issues, in order to add to information gathered or reduce irrelevant data (Burgess 1984). This was useful in the study reported as additional information was obtained at times, such as specific individual feelings about the changes occurring.

6.6.1.3. Interview Framework (Stages 2 and 3)

The interview lasted between 45 - 60 minutes and the framework in Table 6.4 was used to help structure the event (Spradley 1979).

Table 6.4. Framework of interview event

Welcome – Participants are settled and project outlined
Information gathering – Biographical data recorded
Information supplying – Questions asked
Conclusion – Interviewer explains what happens next
(Adapted from Spradley 1979, 1988)

Each stage can be outlined in the study reported here. The 'welcome' stage initially allowed participants to settle. As suggested by Bell (1993) this stage included the following:

- a brief description of the purpose of the investigation
- the potential time to undertake the interview
- information about protecting anonymity
- that all information would be confidential and handled sensitively
  that transcripts would be typed up and sent for approval
- assurance that co-operation was entirely voluntary and that the
  interview could be stopped if they wished
- assurance that participants could refuse to answer questions and that
  they could withdraw from the study if they wished
- strategies for ensuring co-operation including an offer of a final report of the
  study.

It had been found that at Stage 1 additional time had to be built into the interview event for this information to be shared. Thus, interview time was often 45 – 60 minutes per interview.

At the 'information gathering' stage of the interview participants were asked to provide biographical data, such as qualifications, age and present post (Appendices 7, 8 and 9). Denzin & Lincoln (1998) argue that these help settle participants into the interview event. All participants appeared to respond easily to this set of questions.

At the 'information supplying' stage the core research questions were arguably the most challenging to be asked. Many of the questions were descriptive, which Gorden (1975) notes as broadly open-ended. Types of ethnographic questions have been considered by Spradley (1979), who distinguishes between grand tour questions, which result in a rich story and mini-tour questions that focus participants in a more specific format. Both were included in the study reported and examples are illustrated from Appendix 8 in Table 6.5.

Table 6.5. Types of questions and examples from the study

Grand Tour questions:
Example from Question 8; *What organisational preparation have you had (or did you have) for the merger into higher education?*
Mini Tour questions:
Example from Question 10; *Can you give me* three benefits *of your role (perceive or actual) from working in higher educational?*
Adapted from Spradley (1979, 1988)

Burgess (1984) suggests that specified prompts can be built into the interview framework to help responses, whereby possible answers are suggested to help a participant. At Stage 1 prompts had not been planned in the interview schedule (Appendix 7), but were felt to be needed to elicit information and so were planned for in the schedules used at Stages 2 and 3 but were only used if required (Table 6.6).

Table 6.6. Samples of questions containing prompts

Question 3 :Nurse teachers (Appendix 8)
Why did you choose nurse education as a career?

Prompts : Career path to date
Speciality chosen

Question 3 : Clinical Nurses (Appendix 9)
Can you tell me what you know about the current merger of the College of Nursing with Higher Education Institutions?

Prompts: History
Educational issues
Contracts
Nurse teachers' role
Impact on clinical links

At the 'conclusion stage' participants were thanked for their involvement and were reminded that they would receive their interview transcripts once typed. They were also offered the opportunity to receive a final report on completion of the study. It was interesting that the nurse teachers at Stage 2 who were interviewed three times (2a, 2b and 2c) did not appear to require much settling at the 'welcome stage' after Stage 2a. They were, however, very interested in the study findings at the 'conclusion stage' and asked many questions about the development of the study. Although such discussion was stimulating, it could be also time consuming. Gorden (1975) highlights this suggesting 'getting away' is often very difficult after the interview has taken place.

6.6.1.4. Recording the data

Recording the data was considered from the outset including the use of a tape recorder during the interviews. Bell (1993) notes that tape recorders are helpful to check the wording of a statement or to monitor researchers interviewing technique, in order that they can critically appraise their performance. At Stage 1, a series of tape-recorded interviews took place and interviewees were reassured about the confidential nature of the tapes and that they would not be identified in the subsequent analysis. However, Stage 1 participants felt that the tape recorder hindered their answers due to the sensitivity of the information being obtained. The two nurse teachers, in particular, felt that the tape recorder made them feel 'awkward' although the actual questions had not. Consequently, the tape recorder was not used in Stages 2 and 3 for any of the interviews. The decision to do this was important because in ethnographic research a realistic snapshot must be captured. Therefore, if the participants feel, as in this study, that a tape recorder hindered that process then it should be discontinued (Spradley 1979, Denzin and Lincoln 1998). Consequently, each of the interviews was recorded by hand, which was, as Denzin & Lincoln (1998) point out, a lengthy procedure. Bell (1993) notes that the researcher with experience learns to devise their own short hand systems, as was the case in this study.

On the same day as the interviews took place, each was transcribed in full and after typing up, was sent to each participant for their agreement that this was a true representation of their responses. Crabtree and Miller (1992) advise that if the

researcher does this they must be prepared to alter or add to the outlined script. There were only ten occasions with eight participants (out of 72 interviews with 42 participants over Stages 1, 2 and 3) when the researcher had to clarify points transcribed and these were not additional points but rather that the participants felt that the documentation did not reflect the point accurately. The researcher amended the transcripts accordingly.

All the interviews were undertaken in a private office in order to attempt to reduce the possible 'threat' and facilitate recording of data. To assist accurate recording of data, Burgess (1984) advocates that the researcher ensures that each question is fully understood and answered. Only one clinical nurse at Stage 3 asked for several questions to be clarified. After the interview was completed the researcher asked if the schedule had been misleading. She replied that the misunderstanding was due to the researcher's Yorkshire colloquial accent on some words. As the researcher has not lived in Yorkshire for over twenty years this was an aspect not fully considered and so was interesting to learn!

In summary a semi-structured interview format facilitated the data collection in this study. Analysis of the exploratory interviews are discussed in Section 6.10.

6.6.2. Questionnaires (Stage 4)

As highlighted in Section 6.3, in order to meet the aims of the investigation there was a need to determine whether the experiences reported were typical of all nurse teachers at this time. Consequently, Stage 4 of the study was designed to address this wider issue and explore views of lecturers who had undergone a similar institutional merger twelve months previously. Therefore, a questionnaire was developed specifically for this study, using the qualitative interview findings from Stages 1; 2a; 2b; 2c and 3 (Appendices 10a, 10b, 11a, 11b and 12). Wider literature pertaining to nurse lecturer role and merger events theory was also used (Clifford 1995a, Luker et al 1993, Barton 1998, Day et al 1998, Sackmann 1991, Hofstede 1991). At Stage 4, the questionnaire was circulated to 140 nurse teachers at University B and C as outlined (Section 6.5.4). Thus, the questionnaire would explore whether the interview findings reflected the views of nurse teachers in the wider arena, other than one university setting.

Oppenheim (1992 pp100) notes that 'the term 'questionnaire' has been used in different ways'. Essentially, the decision to use a questionnaire depends on the purpose required but it is usually a standard format from which facts, comments and attitudes can be recorded. Traditionally, questionnaires were associated with experimental, quantitative projects. Oppenheim (1992 pp13), however, supports their use in qualitative work, noting that 'we have moved from questions about how many to questions about why'. In support of this, Hague (1993) suggests that the questionnaire need not stand is isolation, but can be used to explore interview

findings and thus add rich data to the study as demonstrated in the study reported here. Hague (1993) also notes that one purpose of questionnaires is being able to draw accurate information from the respondents and so obtain a clearer picture of what is happening. This was the case in the study reported.

Questionnaires are also relatively cheap to produce and results are obtained quickly (Oppenheim 1992). This was particularly relevant in this study, as information was to be gathered from two university sites across a wide geographical area of the Midlands, in England. However, questionnaires do not come without challenges. Anonymity of the questionnaire respondent must be assured, so that the production of candid responses is more likely. Couchman and Dawson (1995) note that respondents are more inclined to show their feelings if anonymity is felt to be certain. On the other hand, Hague (1993) suggests that the singular disadvantage of using questionnaires is the non-response rate, especially in mailed questionnaires, and that any response rate over 60% must be considered to be 'successful' as often response is below 50%. To overcome both of these issues, strategies used in this study included a letter of introduction, which advised potential respondents that anonymity was assured (Appendix 10a).

Oppenheim (1992) notes that, unlike interviews, there is a risk that if poorly constructed questions are used clarification can not be given. Therefore the questions may not yield sufficient data to explore the research objectives. To overcome such problems, Oppenheim (1992) suggests that the questionnaire format

must be orderly, with clear instructions and clear questions in order to facilitate data processing and analysis. Whilst noting this challenge, Hague (1993) states that there must be no obvious bias in the words used. In the study reported the format of the questionnaire was considered very carefully and was 'tested' using a test-retest method, which is discussed in Section 6.6.2.2.

6.6.2.1. Development of the questionnaire

To help develop the questionnaire, the interview transcripts from Stages 2a, 2b, 2 and 3 were read line by line and any 'key repetitive statements or phrases' were taken from the transcripts (Appendix 11a, 11b). This was essential to ensure that questions in the questionnaire emerged out of the interviews. Each of the 'key phrases' were 'reduced' into lists of final key issues (Appendix 12). As a result of this process a mixed qualitative and quantitative questionnaire emerged using a format of eight stem questions, outlined in Table 6.7.

Table 6.7. Focused areas of the questionnaire used in the study

Questions 1 to 3
Includes biographical profile of nurse teachers
Length of time in nurse education
Reasons for entering nurse education

Question 4
Academic, professional and teaching qualifications

Questions 5 to 6
Current Job title
Title used on the telephone to clinical staff

Question 7
Promotion
Status
Contacts with other university lecturers
Teaching of theory /Teaching of clinical skills
Work isolation
Adaptation to rules
Up date of clinical skills
Work related pressure
Adaptation
Student progression
+ One benefit/problem of working in higher education = open ended

Question 8 (Framework identified in the literature review)

Classroom Role – teaching variety, formal lectures and seminar groups.

Student Issues – supervision, support/counselling, communication individual and student groups.

Clinical Role – opportunities, visiting students, communication, time given for clinical skills.

Management/Administration – administration, marking, course/module responsibilities, correspondence and meetings.

Personal – communication senior staff, appraisal, autonomy, job contract, office space, status, communication with colleagues, flexibility, time for role.

Future - academic, research, publication profile, management, networking opportunities

Finally, eight stem questions were devised out of this data with easily identifiable instructions to each one (Appendix 10a, 10b). Questions one to three of the questionnaire included closed questions with tick boxes. The aim of this set of questions was to set the context of the respondent's biographical data, such as age, length of time in nurse education and reasons for entering nurse education as a career. Hague (1993) supports the use of such type of questioning at the beginning of questionnaires, as the respondent will feel able to respond to information about them.

Additional background information, such as academic, professional and teaching qualifications of nurse teachers, was a factor in the interview stages so this formed the basis for the question four of the questionnaire. As this was found to be a complex area due to the diverse experience of nurse teachers, question four gave the respondents the opportunity to add personal information in an open section of three questions aimed to set the context of the respondent's background.

One specific issue that had arisen from the interviews had been confusion that surrounded nurse teachers' current 'title'. Thus, questions five and six were devised to explore this further. Question five related to the title that nurse teachers were given by the organisation, such as Lecturer or Senior Lecturer, and Question 6 referred to those titles that they commonly used in conversation with clinical staff, such as Nurse Tutor.

Question seven of the questionnaire included closed, structured questions that sought to obtain respondents' perceptions of the nurse teacher role in higher education. Ten statements were developed using Likert scales, which Oppenheim (1992) defines as types of closed questions that incites respondents to respond by agreeing or disagreeing with the statement. In this study, respondents were asked to circle whether they agreed or disagreed with the statements using a scale of one (strongly agree) to five (strongly disagree). Following this, two open-ended questions asked respondents to note one benefit and one problem of their role in higher education. In this way they were able to answer freely, but the questionnaire remained focused (Oppenheim 1992). The specific focused areas of Question 7 are included below and the format used is shown in Table 6.8.

• Promotion	question 7.1
• Status	question 7.2
• Contacts	question 7.3
• Teaching of theory	question 7.4
• Isolation in role	question 7.5
• Adaptation to rules	question 7.6
• Up date of clinical skills	question 7.7
• Pressures of role	question 7.8
• Expectation of organisation	question 7.9
• Student progression	question 7.10

Table 6.8. Examples of question 7 format

Listed below are a number of statements to explore your perceptions of YOUR nurse lecturer role. Please CIRCLE the number that you MOST feel relates to your feelings

Key to Scale

Strongly Agree = *SA (Number 1)*
Agree = *A (Number 2)*
Neither Agree/Disagree = *NA/D (Number 3)*
Disagree = *D (Number 4)*
Strongly Disagree = *SD (Number 5)*

	SA	*A*	*NA/D*	*D*	*SD*
7.1. In the Higher Education system my chances of promotion are limited	1	2	3	4	5

7.12 Can you identify one problem of your role in higher education institutions?

The final question, eight, used 'satisfaction' scales, which Hague (1993) suggests are types of attitudinal questions that provide 'benchmarks' for comparison. Brannigan et al (1993) found that if 'satisfaction' was explored in isolation it was problematic, as satisfaction of the experience did not capture the total learning experience. Therefore, in order to overcome this an 'importance' rating was presented alongside satisfaction to identify what is also important to the respondent. In this way a more complete picture can be obtained.

Satisfaction/importance scales in terms of research technique have been used in other health care sector studies and were found to have great potential in evaluating respondents' views as a more complete picture is sought (Johnson et al 1988, Carnwell & Moreland 1999, 2000, Werrett et al 2001). Using the principles of this approach, the aim in this study was to contrast the importance of a given subject,

such as teaching administration, student group sizes, and clinical links, alongside the perceived satisfaction levels of that, as part of the role (Brannigan et al 1993).

When developing importance/satisfaction scales questions should be kept short to ensure maximum response (Werrett et al 2001). Within the stem of question eight, respondents were presented with 30 closed options (Appendix 10b). The 30 items within question eight were randomly presented to avoid bias that may be introduced by sequencing or grouping questions (Werrett et al 2001). An example of the stem and format is included in Table 6.9.

However, Oppenheim (1992) suggests that, whilst such scales are useful to obtain responses quickly and are easy to analyse, one problem is that respondents do not feel that they are able to control the variables in the same way as an open format. To overcome this, in the study reported, respondents were given the opportunity to respond using an open-ended 'additional comment section' at the end of question eight.

Table 6.9. Example of question 8 format

Listed below are a number of factors that may be attributed to the nurse lecturers' role. Please indicate with a TICK on the scale the extent to which you are SATISFIED with the aspects and then rate how IMPORTANT they are to you.

	Satisfaction					**Importance**				
	Very Dissatisfied				Very Satisfied	Not important				Very important
	1	2	3	4	5	1	2	3	4	5
8.1. Opportunities to develop clinical skills	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In summary, the development of the questionnaire was based on good principles of questionnaire design described by a number of authors. The findings from the qualitative interviews in Stages 2a; 2b; 2c and 3 and wider literature informed this process. This was felt to be a useful tool in building up a picture of the nurse teacher role in the wider arena of two other university settings.

6.6.2.2. Pre-testing the questionnaire

Stage 4a included pre-testing of the questionnaire (page 160), the aims of which were:

- To test accessibility of the information required.
- To discover if the instructions and question stem and format were understandable to the group of nurse teachers
- To test how much time was required to complete the questionnaire format
- To determine if there was a need to restructure the questionnaire to ensure smooth data analysis.

A decision was made to undertake a test-retest method on the questionnaire in the study reported. A useful guide for the test-retest method is outlined by Bell (1984), where she notes that this is when draft questionnaire tools are subjected to two rounds of scrutiny by a small sample of subjects from the same population as the main study. In this way, mistakes of error caused through ambiguity of questions can be reduced and so improves the internal validity (that is to test how well an instrument measures what it purports to measure).

The first draft questionnaire was sent to a convenience sample of five nurse teachers in University B, with a covering letter explaining the purpose of the pre-testing process and a comments feedback sheet (Appendix 13a, 13b). Using the principles described by Bell (1984), respondents were asked to complete the questionnaire and return it within two weeks in the stamped address envelope provided. All five respondents sent the questionnaires back within the two-week period. Overall, they noted that the questionnaire took between 30 and 45 minutes to complete. Hague (1993) suggests that this is an optimum time as longer than 45 minutes reduces response rates.

All five respondents made suggestions about the layout of the questionnaire suggesting that more space was needed for open ended question responses (questions one to six specifically) and three respondents suggested that clearer instructions for the stem of question eight was required. Two respondents added that some additional aspects of the nurse teacher role needed greater clarification. These included issues related to 'adherence to rules, teaching of large groups, teaching and supervision of research as part of research activities and office space'. As a result of their comments modifications were made to the design of the questionnaire, following which the 're-test' questionnaire was devised. This was sent to the same five respondents for their approval with a two-week period return and a stamped addressed envelope. After the period of time no changes were suggested, although three made comments about the clarity and ease of the questionnaire.

In summary, the test-retest method was useful in developing the questionnaire tool and gave rise to a number of changes in the questionnaire design for use at Stage 4b.

6.6.2.3. Distribution of the questionnaire

The questionnaire at Stage 4b included a supplementary letter of introduction, which was sent to each of the 140 nurse teachers sampled at University B and C (Appendix 10a). Using Bell's (1984) principles, the potential respondents were sent the following information:

- the researcher's name, contact telephone number/address
- a brief description of the purpose of the investigation
- a statement protecting their anonymity and confidentiality of data
- assurance that co-operation was entirely voluntary
- assurance that respondents could leave questions or add information
- potential time to complete the questionnaire
- an accompanying instruction sheet about the questionnaire format
- that the final report via named senior faculty staff would be made available six months after the final questionnaires were received.

Questionnaire response was assisted through circulation via two key individuals in senior positions at University B and C. They offered to distribute the questionnaires via the internal post to all the nurse teachers who had moved into the university as a result of the merger with the college of nursing. These contacts also

agreed to accept the returns after four weeks so that the completed transcripts could be collected in one batch. After four weeks, a letter was sent to remind the same groups of nurse teachers about the questionnaire and they were given a further two weeks before a final collection took place, reflected in the recommendation by Bell (1984) who suggested a time frame is useful in order to commence analysis as the data is received.

The questionnaire was sent to University B and C. University B was the larger of the two universities, and 100 questionnaires were sent, whilst staff at University C, which was smaller, were sent 40. Access was negotiated through the Deans of the Faculty as described later (Section 6.8) and each Dean had identified a senior member of their staff to support the distribution. The two individuals were key to the distribution and ultimate response of the questionnaire. Each key individual had available to them a list of the nurse teachers who had previously worked in the colleges of nursing and sent the questionnaires via the internal post directly to them. As outlined, both staff also offered to identify a 'collection point' for the completed questionnaires, which was helpful as it meant that 'batches' were simply collected from University C and posted from University B within the suggested time frame.

6.7. Trustworthiness

The issues of rigour, trustworthiness, the decision trail and reliability are important considerations in any project. Guba and Lincoln (1989) make a case that in multiple methods, as used in this study, the guiding principle of 'trustworthiness' should be used, within which four aspects can be demonstrated. These are credibility, transferability, dependability and confirmability.

6.7.1. Credibility

To establish credibility researchers must ensure that those participating are described and experiences interpreted accurately (Guba and Lincoln 1989). One action to ensure this is to use method triangulation as suggested by Robson (1993). As reported earlier in study (Section 6.3.2), methodological triangulation was used incorporating a range of interviews at Stages 1, 2 and 3 and follow up questionnaire at Stage 4.

In order to describe experiences accurately in this study and due to the multiplicity of data in the categories, a coding system was devised, from which information could be retrieved and organised (Wilson 1969, Morse 1994). Miles and Huberman (1994) note that 'codes' are descriptive labels assigned to 'chunks' of words, sentences or paragraphs in order to summarise the content. In this way data can be retrieved using the codes and managed more efficiently. Leininger (1985) notes that interview transcripts can also be 'coded' by using the line numbers as part of the

strategy for credibility. Alternatively, Morse (1994) suggests that this is not always necessary in qualitative work as the 'codes' can be assigned to key phrases, which is the essence of the participants' views, as was the chosen method in the study reported.

Stage 1 data analysis also helped to develop the system of coding used in the study reported. Miles and Huberman (1994) suggest a framework whereby a manual 'start list' is created from the data whereby a master list of codes is attached to responses. Thus, in the study reported, a 'start list' of master codes using key letter digits from the actual responses of participants was created. Consequently, **three** key letters were attached to each of the nine categories (Appendix 14). **Five** additional key letters were subsequently added to the responses to be used as a second 'digit code' list (Appendix 15). As a result, the categories had been effectively generated and were used to rapidly examine responses and retrieve data across respondents.

As outlined, an independent peer review was undertaken after the Stage 1 interviews and the transcripts were analysed with respect to the coding system. It was agreed that the coding system used was consistently reflecting the information that had been given. To add additional verification, two participants were asked to ascertain if their transcriptions were fairly interpreted, both in relation to objectivity and understandable coding rules (Morse 1994). Although they both felt that the transcriptions were analysed adequately, one felt that some idiosyncratic beliefs were omitted as a result of the data reduction process (Section 6.10). For example,

it was noted that some nurse teachers were feeling a sense of loss as a result of the imminent merger, and that this had been alleviated through the interview event. Morse (1994) discusses that participants may view the researcher as a source of help, which conflicts with a researcher's need to remain detached. This was difficult dilemma but enabled the researcher to acknowledge individual issues that participants may have had which inevitably helped inform Stages 2 and 3 of the study.

The coding described was used consistently at all the stages of the study. This is supported by Morse (1994), who suggests that consistent coding rules help assess the reliability of existing data in comparison to new data. It was found to be a useful framework and appeared to assist the recording of significant data at this stage of the study.

6.7.2. Transferability

Transferability can refer to the how the finding can be transferred or generalised, but in exploratory work Morse and Field (1996) should refer to the characteristics and settings of those involved in the research. These aspects in this study have been described in detail elsewhere (Sections 6.4 and 6.5). However, one aspect not covered is the ethnographic principle that the researcher attempts to record data through the participants' eyes (Spradley 1979). The need to understand the group is therefore important if their characteristics and setting is to be fully understood.

In this study, the researcher was also a nurse teacher experiencing a 'merger event' and was as Denzin and Lincoln (1998 pp334) refer, an 'inside researcher'. Spradley (1979) warns that this can create a situation of role confusion for the researcher and indeed there are numerous accounts of the dilemmas that this can create, and in some cases even to the point of being verbally and physically attacked (Denzin and Lincoln 1998). For this study, the principles suggested by Burgess (1984) were finally decided upon. Burgess (1984) suggests that insider knowledge is important as the researcher has an understanding of the words and language before entering the field. This is clearly witnessed in feminist research where research by women on women has opened new ideas and richer understanding. This can also be said of insider ethnographic work. Thus, in this study it was decided that being an 'insider' would help to understand the participants' perceptions and feelings and would significantly contribute to the depth of the work. Throughout the study reported, the effects of the insider role were seriously considered and were addressed through external process checks as discussed below.

6.7.3. Dependability

Guba and Lincoln (1989) note that process checks need to be made in order to ensure that the research is dependable. Strategies included a series of independent peer /subject reviews following data collection at Stages 1, 3 and 4. This helped the decision trail where links could be made and choices analysed. Furthermore, in the study reported, reflective memos were written at Stage 2a, 2b, 2c and 3, following which discussions and presentations took place with nurses who had background

knowledge of the merger of nurse education into higher education (Coad 1998, 2002). This was useful in ensuring that the principles of dependability were adhered to.

6.7.4. Confirmability

The fourth aspect for establishing trustworthiness is confirmability, which is that the data links together so that the work is logical and interpretations arise out of the data. Robson (1993) suggests the following principles are required and in this study have been outlined in the previous sections but are presented as a reminder:

- The methodological underpinnings of the study are in keeping with the data collection tools, which was felt to be the case in this study as discussed in Section 6.3.
- Any of the interviews or questionnaire could have disturbed the natural state of the participants such as the impact of explaining their feelings. To overcome such issues the researcher was sensitive about the handling the data during the collection stages.
- Attempts were made to ensure that the raw data was stored logically; in this case at each stage memos were used, interview transcripts were written up promptly and questionnaires were collated using Microsoft Excel and SPSS.
- The formation of the findings emerges out of the data, which will be demonstrated in the data analysis (Section 6.10).

In summary, using the four guiding principles of 'trustworthiness' have demonstrated that the study reported was logical and has established that the decision trail was detailed and well thought out.

6.8. Access and Ethical considerations

Access and ethical considerations are paramount to any investigation and in this study are considered using the three basic principles suggested by Beauchamp and Childress (1989).

6.8.1. Beneficence.

This emphasises that the outcome of the study should be of value and that it is performed in a manner that does not cause harm to the participants. Firstly this occurs through gaining access. General access to the institutions was obtained through the ethical committees of College A and University A (Appendix 16a). University B and C at Stage 4 were accessed through the consent of the Dean of Faculty. In Hospitals A, B and C, ethical committee consent was not required as patients were not involved, so access was negotiated with the respective hospital director of nursing, ward managers and clinical staff (Appendices 16b, 16c).

With respect to individual access in the interviews at Stages 1, 2 and 3, this was negotiated after the sampling had occurred and the participants had agreed (Page 160). For example, the study reported here at Stage 2, focused on nurse teachers as the merger into higher education took place, so there was a risk of causing distress nurse teachers who may have been worried about their future employment opportunities and role. In order to minimise distress, at Stages 1, 2 and 3 of the interviews the 'welcome' and 'conclusion' stage were used to assure

confidentiality, and at Stage 4 (questionnaires) issues of anonymity of data were included in the introductory letter. Furthermore, in order to protect participants' anonymity, each were allotted a 'code' that related to the stage of the study and a number (such as Interviewee 1.1 relating to Stage 1; participant 1). This allotted code was used consistently during data analysis and subsequent presentation of results.

6.8.2. Respect.

This principle includes the right to full disclosure and self-determination, which the RCN (1993, 1998) note is that potential participants have the right to refuse to participate. Potential participants were informed in the introduction of the interview and questionnaire letter that co-operation was entirely voluntary. The wishes of all participants who agreed to participate were respected. As indicated elsewhere (Section 6.5.2), from the 20 nurse teachers sampled initially at stage 2, five nurse teachers refused to participate. The wishes of those not wanting to participate in the study were respected.

The RCN (1998) notes that researchers can have considerable 'power' whereby participants feel compelled to participate. In order to overcome such issues, autonomy and control must be given to participants about whether to answer questions or not. As outlined, both in the interviews and questionnaire, participants were assured that they could refuse to answer any questions if they preferred not to answer. On one occasion at Stage 2a interviews, one of the nurse teachers became

very upset and in keeping with the ethical principles adopted, the researcher asked if she wanted the interview to stop. However, this was refused as the participant felt that it was useful to encapsulate her feelings as part of the 'merger event'.

Oppenheim (1992) also suggests that participants are given an outline of what would happen to their data and how they would be informed of the outcomes of the study. At the 'conclusion' stage of the interviews and in the introductory letter of the questionnaire, this was outlined. At Stages 1, 2 and 3, each participant received their interview transcripts, a thank you letter and an invitation to be added to the final report distribution list. All those interviewed accepted this offer (n=42). In the questionnaires it was outlined in the introductory letter that a final summary of the findings would be sent to senior staff at University B and C, six months after completion. This will be adhered to as a thesis summary following completion.

As outlined elsewhere (Section 6.3.3), Marsland (1999) notes that in longitudinal studies it is imperative to maintain interest and commitment. At Stage 2 of this study, participants were interviewed three times over a period of 18 months. Therefore, each participant was made aware that participation meant agreeing to be interviewed on several occasions over the period of eighteen months. They were kept informed of the project through devising a six-monthly newsletter of the progress (Appendix 17). Gilbert (2001) suggests such strategies keep the project alive and allow participants to feel useful. In feeling this they are more likely to co-operate at a later date whether that is on the current investigations or indeed

another. It was also noted that whilst any participant was able to withdraw at any time during Stage 2, no participant did withdraw.

6.8.3. Justice.

This refers to the importance of ensuring that the research does not exploit the participants and confidentiality is maintained. The researcher assured all the participants at each of the four stages of their anonymity. However, the RCN (1993) emphasises that in any rigorous project, scrutiny for ethical flaws often results in aspects being overlooked. As discussed, a series of codes were devised to prevent disclosure of the interview transcripts and questionnaires. However, it was interesting that one of the response envelopes at Stage 4b had an innocent ink mark on it and one respondent commented as to whether this was a secret identification mark, which it was not!

6.9. Summary of methodology

To date this chapter has reported on the design of the longitudinal study reported here and has aimed to justify the use of exploratory semi-structured interviews on a group of nurse teachers in one university and questionnaire survey that aimed to test the findings with a larger population of nurse teachers across two other universities. The next section will discuss the data analysis and findings at each stage of the interviews.

6.10. Data Analysis

6.10.1. Introduction

This section will discuss the techniques used for data analysis of the exploratory interviews undertaken at Stages 1, 2 and 3 and the questionnaires at Stage 4. Figure 6.1 illustrates the stages of the research as outlined previously, but here includes the process of data analysis.

6.10.2. The process of data analysis

Data analysis has been described simply as the systematic organisation and synthesis of research data (Strauss and Corbin 1990). Several authors have suggested that qualitative data analysis contains no rigid methods or tests that can be adhered to (Miles and Huberman 1994, Morse and Field 1996). It is the data itself that is used to create concepts, patterns, themes and categories, but Morse and Field (1996 pp103) suggest that the data itself is not enough, but rather it is the 'immersion and complete familiarity with the data' that creates emerging theory.

Figure 6.1. Stages of the study including the analysis process

Stage 1 (pilot)

Interview pilot study involving semi-structured interviews with 2 nurse teachers, 2 students, 2 clinical nurses and 1 university lecturer prior to the merger of nursing colleges into higher education.

↓

Analysis of interview transcripts ⟺ Peer review

↓

Development of interview tool and codes created

Stage 2

In-depth exploratory interviews of a group of 15 nurse teachers using a longitudinal interviews (x 45 interviews) at **Stage 2a (3/12 prior to the merger), 2b (at the 'merger point')** and **2c (12/12 months after the merger)** into one HEI

↓

Analysis of Stage 2a, 2b and 2c interviews

Stage 3

Interviews with a group of 20 clinical nurses one year after the merger into higher education

↓

Data Analysis of Stage 3 interviews ⟺ Peer/ Subject review

Stage 4

Questionnaire designed from interviews of Stages 2 and 3 and pre-tested at Stage 4a with a sample of nurse lecturers **(n=140)** in two other HEIs after the merger used at Stage 4b

↓

Data Analysis of Stage 4 questionnaires (informed from interviews) x 98 ⟺ Subject review

Data analysis of ethnographic based work is challenging and sources can appear confusing. Roper and Shapira (2000) note this is acceptable given that it is the huge amount of data generated that will direct the process of data analysis in each study. However, 'key' authors are evident, some of which include Burgess (1984), Fetterman (1989), Miles and Huberman (1994) and Morse and Field (1996). All agree that data analysis is time consuming, driven by the data (inductive), begins as the data is collected and requires strategies for coding, sorting and generalising patterns.

There are several suggested models to classify the type of analysis in qualitative work. Two commonly used ones in ethnographic work are thematic and content analysis (Morse and Field 1996). Thematic analysis involves the search for abstract, common threads indicated in the data, whereas content analysis is analysis by topics, which are segmented into categories (Morse and Field 1996). Morse (1994) notes that thematic analysis has the advantage of pulling out the richness of the behaviour, but can be difficult to identify, especially in analysis of interview transcripts. Content analysis, however, is useful with interview data, as it allows the researcher to focus on the text and use the 'key' phrases that participants frequently use to produce descriptive, inductive findings. A decision was made to use content analysis in this study, as it was felt that it was essential that the 'key concepts' were identified by the participants and that it was their words that should directly inform the work, thus aiming to add to rigor (Wilson 1969).

Within the chosen classification system, a strategy for the organisation of data is also required (Wilson 1969). Two processes include those described by Miles and Huberman (1994) and Morse and Field (1996). Miles and Huberman (1994) describe qualitative data analysis as having four interconnecting stages of data collection, data display, data reduction and drawing conclusions/verification. On the other hand, Morse (1994) suggests four alternative stages of comprehension, synthesising, theorising and re-contextualsing.

Whilst Miles and Huberman (1994) and Morse (1994) use different conceptual frameworks, the outcomes are generally comparable. Thus, a decision was made to use the overall titles and framework suggested by Morse (1994) as this was felt to be a more integrated approach, whilst Miles and Huberman (1994) informed the analytical process within the framework, with the aim of making assimilation of the findings easier. This is supported by Holliday (2002) who notes that in making decisions about which data analysis model to use, it must feel right for the study. This was the case in the study reported here.

6.10.3. Comprehension

Morse (1994) notes that comprehension is the reading and re-reading, line by line, of the data collected. It is only reached when the researcher has enough data to be able to write a complete and rich description of the event. However, in order to achieve this, data display, must be achieved (Miles and Huberman 1994). These principles are related to the stages of this study.

6.10.3.1. Stage 1

The first stage of comprehension in the study reported involved an in-depth review of the Stage 1 interviews by transcribing all of the seven interviews in full, line by line. Morse (1994) suggests that the reason for using a disciplined approach is to describe and explain the essence of the experience and meaning in the participants' lives. In keeping with the principles of content analysis, transcripts were displayed, read and re-read in order to identify the key responses and codes attached as described elsewhere (Section 6.7.1). Spradley (1979) describes this initial process as crucial if ethnographic data is to be meaningful. This method was undoubtedly time consuming and labour intensive, but it was felt that, in undertaking this approach with all seven participants at Stage 1, it helped develop the researcher's data analysis skills and so enabled the subsequent interview data to be gathered at Stages 2 and 3 more efficiently.

The emerging 'key responses' were underlined in order to identify 'categories', a process which yielded many inter-related comments that participants had used in their responses from the interview transcripts. As a result, data from Stage 1 resulted in the identification of 75 broad categories of 'key responses' (Appendix 18a).

The next stage was to reduce this data and therefore a process of 'data reduction' was undertaken (Morse and Field 1996). This involved the researcher 'selecting, focusing, simplifying, abstracting and transforming the data' (Miles and Huberman

1994 pp10). In order to simplify the data reduction, a process of 'concept mapping' was employed, whereby descriptive labels are given to the emerging patterns (Morse 1994). Miles and Huberman (1994 pp248) suggest that patterns become apparent as data are sorted into groupings or piles of 'things that are alike or not unlike each other'. Thus, the researcher sorts the patterns into smaller groups (or piles) looking for specific categories and ultimately the content analysis outlined gives rise to the emerging patterns or themes (Morse 1994). In the study reported at Stage 1, this process was undertaken so that all of the 75 broad issues became 'paper labels' and were laid out as 'key concepts' (Appendix 18a). Associated concepts were grouped together and were subsequently placed into named categories, which resulted in eight 'categories' or 'themes' (Table 6.10).

To validate the process, 'peer review' was performed by an independent researcher, who examined two of the interview transcripts. This person was familiar with qualitative research methods and higher education merger issues as suggested by Holliday (2002). This review indicated that some of the eight conceptual themes should be given greater clarity in their titles and that one (higher education preparation and knowledge) needed breaking down into two dichotomous categories.

As a result, nine categories were identified with a multiplicity of subcategories (Appendix 18b). Table 6.10 illustrates the changes made as a result of the peer review. Using the categories enabled the researcher to organise 'key responses'

thereafter. This was useful as 'key responses', words or phrases could be counted in the transcripts, identified on the line of the transcript and placed in simple, numerical order, a process that Morse (1994) suggests can not only assist to make sense of the event but also presentation of results.

Table 6.10. The nine categories identified at Stage 1, 2a, 2b and 2c

(1st Review)	(2nd Review)
1. Job Title and post	1. Current Job Title/Preferred title/ present post
2. Career Plan	2. Biographical data/ Career Plan/length of time in Education/qualifications
3. Nurse teacher attributes (Current and future) 4. Nurse teacher role attributes (Current and future)	3. Current Role attributes 4. Future Role attributes
5. Cultural and Organisational Understanding	5. Current Cultural and Organisational Understanding
6. Higher Education Preparation and knowledge (Organisational and Personal)	7. Personal Higher Education Information Organisational Higher Education Information
7. Issues in higher education (Benefits and problems) 8. Effect of merger on role of nurse teachers (nurse training)	8. Benefits of role in higher education 8. Problematic issues of role in higher education

6.10.3.2. Stage 2

The nine categories were used to present findings at Stage 1 and to assist structure of the interview tool used at Stage 2. At each of the stages 2a, 2b and 2c of the study, the transcripts were reviewed for emerging issues using the previously identified processes and categories. Examples of this process from Stage 2a, 2b and

2c are presented in Appendix 19. In summary, the 'key responses' at Stages 2a, 2b and 2c reflected the categories identified in Stage 1 and thus were used throughout. Morse (1994) supports the use of consistent categories in improving the validity of findings.

6.10.3.3. Stage 3

The nine categories were used to assist the structure of the interview tool used with the clinical staff at Stage 3. However, the differing perspectives offered by the clinical staff meant that interview framework adopted in Stage 2 was not appropriate. Therefore, a further review of emergent data took place in order to build up a picture of the emerging themes and patterns of the data gathered at Stage 3. One examples of this process from Stage 3 is presented in Appendix 20. Morse and Field (1996), describe this as responding to the nature of qualitative data. As a result, new themes were identified from the data for the clinical nurses group as outlined in Table 6.11.

Table 6.11. Themes used for Clinical Nurses Group (Stage 3)

	Category
1.	Contextual information
2.	Perceptions about the merger into higher education
3.	Perceptions of the nurse teacher role in higher education
4.	Communication issues with nurse teacher

6.10.3.4. Stage 4

Following the interviews at Stages 1, 2 and 3, as outlined elsewhere, the questionnaire was developed for Stage 4 using the emerging 'key responses' and findings (Appendix 11a, 11b). The findings were scrutinised and repetitive findings were isolated. A decision was made to use a qualitative and quantitative layout in the development of the questionnaire to add to interest and potentially increase response rate (Oppenheim 1992).

Denzin and Lincoln (1998) suggest that in the data analysis process the researcher may consider to use triangulation of data where one data set is compared against another searching for patterns or relationships. In this study it was felt that whilst methodological triangulation methods as discussed in Section 6.3.2 were used, a decision was made not to triangulate the findings in the data analysis process. This was because both were different settings and resulted in different data sets, a decision supported by Silverman (1993). Roper and Shapira (2000) also advocate the use of keeping qualitative and quantitative work separate suggesting that quantitative data will often dominate the rich picture of qualitative work. Roper and Shapiro (1999) also note that a more complete picture is then achieved by bringing the work together in a final discussion section. This was adopted for the study reported here.

Much thought was given to comprehension of the questionnaire data of this study. Bell (1993 pp89) suggests that ' it is perfectly possible to produce a good report without extensive statistical representation'. Using this principle, quantitative data in the questionnaire was subjected to analysis by Microsoft Excel and SPSS (Foster 1993). Following this process, it was decided that findings should be presented using descriptive statistical analysis being represented as numbers or percentages as outlined in Chapter 10. Furthermore, cross-tabulation was used to identify patterns of responses within the theme groups, which were found to be very useful in the study. The reliability of the quantitative scales of the questionnaire was determined by a coefficient alpha of 0.83 indicating high reliability. Qualitative data has been categorised and presented in descriptive format, also in Chapter 10.

6.10.4. Synthesising

Morse (1994) suggests that in the synthesising stage, the researchers get a feel for the sifting of data. In other words significant values, attitudes or beliefs become evident. Morse and Field (1996 pp105) note that it is the stage when the researcher 'can describe the norms eloquently' to others. In the study reported, this process began after Stage 2b. At this stage in this study, the interview events began to link together, not as a singular transcript, but as a whole (like a jigsaw fitting together). As the jigsaw came together 'cultural patterns' could be identified as nurse teachers went through the transition from working in a college of nursing in the NHS to working in HEIs. This would seem in keeping with the underpinning principles of ethnographic methodology used in this study.

Miles and Huberman (1994) suggest that one method to help the researcher with such insights is to use field memos. In simplistic form, field memos pull together notations that have commonalties to allow the researcher to have 'little conceptual epiphanies' (Miles and Huberman 1994 pp74). In this way synthesis can be achieved. As highlighted in Section 6.7, in the study reported, reflective memos were written at Stages 1, 2a, 2b, 2c and 3, following which useful discussions and presentations took place (Coad 1998, 2002). Roper and Shapira (2000) note that such presentations of findings are useful in the synthesis process as the questions from the audience can serve to challenge and subsequently re-think the work.

6.10.5. Theorising

According to Morse and Field (1996), theorising can be thought of as the 'sorting' phase of the data analysis. Briefly, it is the stage when the selection of supportive theory and alternative models are considered to support the findings of the study. Theory is described as 'not reality but a representation of it' (Morse 1997 pp185). A theoretical framework, therefore, can be seen as theory derived from the findings of previous work to help structure another project.

There is much discussion in the literature about the use of a theoretical framework noting that the decision must be considered very carefully. Miles and Huberman (1994) state that one decision is whether a researcher decides upon a pre-existing framework prior to fieldwork or uses no framework preferring naturalistic,

inductive enquiry. They argue that tighter designs from the start of data collection can help to focus and 'bound' the collection of data and subsequent analysis (Miles and Huberman 1994 pp16). However, Morse (1997 pp168) notes that a pre-structured framework is limiting, as a framework is likely to emerge as the data analysis process occurs. There is a risk that a researcher may try to 'force' their findings into an existing framework. Thus, decisions about a framework should not be pre-empted or rushed, must be inductive and innovative if the study is to 'represent the empirical world'.

The use of a theoretical framework was considered carefully in the study reported. Following analysis of the transcripts a decision was made that whilst the 'categories' at Stage 1, as described, were useful, a theoretical framework may add to the clarity and representation of emerging findings. This was explored by re-reading key pieces of literature whilst also re-reading the data that was being collected. As more data was collected (and more analysis occurred) a decision was made to personally contact one of the authors used in the review from the established field of organisational culture theory which was Sackmann (1991) (Chapter 5). Sackmann's (1991) framework had been found most useful in the background literature and potentially might have been useful in this study. Sackmann (1991) was helpful to the decision-making process and whilst she gave permission to use her framework she suggested that the nine identified categories (Table 6.10) were broad enough to allow the data to naturally evolve. It was thus

decided that a theoretical framework would be devised from the emerging issues from Stages 1, 2, 3, and 4 for the discussion phase.

6.10.6. Re-contextualsing

Morse (1994) notes that this stage has the 'real power' as it is the stage where the emerging theory is applicable to other settings and other populations. It is thus the theory that can be generalised and re-contextualized to other settings. Miles and Huberman (1994 pp279) refer to this stage as the 'truth value' of the findings and 'an authentic portrait' of what has been recorded known as 'internal reliability'. At the same time external validity, which relates to the 'transferability' of the interpretations found, should become evident. In relation to the study reported the emerging findings were used to develop a framework, which was subsequently used for the discussion (Chapter 11).

6.11. Summary

The overall purpose of the study was to explore the perceptions of nurse teachers' role as they move from working as 'nurse tutors' in colleges of nursing located in the NHS to 'lecturers in nursing studies' in HEIs. This chapter has reported on the design of the study reported here and discussed the data analysis process at each stage of the interviews and questionnaires. With respect to data analysis, using the principles and techniques outlined, content analysis was undertaken following the interviews at Stages 1, 2 and 3 and the questionnaires at Stage 4. It was felt that each stage demonstrated progression, whilst also responding to the emerging issues of the data collected.

Further evidence of the methodological underpinnings of the study reported is illustrated in the descriptive and interpretive findings located in Chapters 7, 8 and 9 (interview findings) and Chapter 10 (questionnaire findings).

Chapter 7

Stage 1 Findings

7.1. Stage 1

The aim of the Stage 1 was to serve as a pilot to the main study through a series of semi-structured interviews (Appendix 7). As outlined in Chapter 6, it included a sample of two nurse teachers, two students, two clinical nurses and one university lecturer prior to the merger of nursing colleges in the NHS into higher education. Findings are summarised using categories as outlined previously in Table 7.1. In order to ensure rigor, as suggested by Morse (1994), findings are presented using direct quotes in italics followed by each participant's code. The numbers in each table refer to the number of times a 'key' phrase was used.

Table 7.1. Categories used for presentation of findings

1. Current Job Title/Preferred title/ present post
2. Biographical data/ Career Plan/length of time in education/qualifications
3. Current Role attributes
4. Future Role attributes
5. Current Cultural and Organisational Understanding
6. Personal Information about Higher Education
7. Organisational Information about Higher Education
8. Benefits of role in higher education
9. Problematic issues of role in higher education

7.2. Nurse teachers

This section summarises findings of two female nurse teachers (Interviewee 1.1 and 1.2) from College A prior to the merger of nurse education into higher education.

7.2.1. Current job title/preferred title

Both of the nurse teachers discussed issues pertaining to their title. At Stage 1, both nurse teachers were titled, 'Nurse Tutor' and felt 'comfortable' about this. One nurse teacher noted that she used her first name in communicating with people who knew her, for example on the telephone. Both felt that the title of 'Nurse Tutor' was an accepted title in nursing for nurse teachers but indicated that they believed the title of nurse tutor' would change with the forthcoming merger into higher education.

7.2.2. Career Plan/ Biographical data

Biographical data was readily ascertained from both nurse teachers. Findings indicated that they had had similar career paths of nurse education and experience, and worked in senior management positions prior to entering nurse education. Interviewee 1.1 had entered nurse education eight years prior to the interview whilst for interviewee 1.2 this period was five years. Interestingly, both could recall vividly the people (or person) who had inspired them to enter nurse education.

Interviewee 1.1 stated:

'that they hoped in education they could share and teach the students good principles to use on the ward' (Interviewee 1.1).

In addition, both had worked as 'Clinical Nurse Teachers' in the school of nursing (prior to becoming a college). Both were 'unqualified' in these posts as the Registered Clinical Nurse Teacher (RCNT) qualification had already been abolished. After a period of time in these posts both nurse teachers had undertaken a Registered Nurse Tutor (RNT) course and in so doing followed a career route similar to the large majority of nurse teachers (Chapter 3; Section 3.3).

7.2.3. Current Role Attributes

Considerable time was spent discussing current roles. One taught on the Common Foundation Programme with the pre-registration students whilst the other was largely responsible for post-registration delivery. A list of 'key' attributes were devised, listed in Table 7.2 using the number of times that attributes were referred to within the interview event and are reflected in the findings of other studies namely the work of Luker et al (1993) and Clifford (1995a).

Specific comments related to the participants' current role is illustrated:

'I see teaching as having both a classroom role and a clinical role – both are important grounds for teaching and communicating to students which is what this job is really all about' (Interviewee 1.1)

'Its important to have good teaching skills. The students respect that and in addition when they come to me I try to be very supportive of their needs – not overprotective but accessible and approachable. (Interviewee 1.2).

Table 7.2. Key current role attributes identified by nurse teachers at Stage 1

Attribute	Respondent 1	Respondent 2
Nursing Expertise	12	11
Good Communication skills	9	10
Teaching skills	11	8
Academic Expertise	6	5
Theory/Practice Skills/attitudes	3	8
Classroom role	6	3
Clinical role	2	6
Administration	2	5
Development of students (Supportive/help)	5	2
Organisational management	3	4
Questioning	1	4
Positive Role Model	1	4
Motivated	2	2
Adaptation skills	1	3
Self Management	2	1
Networking opportunities	1	2
Research & Publishing	1	2
Autonomy	1	0
Wider networking	0	1

Responses can be further broken down into classroom role, management and administration role, and clinical role thus illustrating the multiplicity of dimensions of the nurse teacher's role.

7.2.3.1. Classroom role

Both nurse teachers purported to spend a lot of time in the classroom although this was seen as '*about the right amount of time' (Interviewee 1.2)*. They stated that this kept them in contact with the students, that this time was stimulating and challenging and that they enjoyed seeing students develop. Interviewee 1.1 had found that in the last year she had taught in large groups which '*was less than enjoyable as it was difficult to do the group work to the same degree'*. Both reported it was very difficult to ensure that classroom teaching was up to date if they were unable to develop clinically.

7.2.3.2. Management and administration role

Both participants felt that too much time was spent at *'various meetings'* and *'being caught up doing trivial administration like standing at the photocopier!* Interviewee 1.1 felt that more administration staff were needed to fulfil this role which she felt '*took her away from teaching'*. This supports Nolan (1987) and Clifford's (1995) findings whereby dissatisfaction was cited about the amount of managerial and administrative type of work.

7.2.3.3. Clinical role

An important aspect was that in order to perform their classroom role effectively nurse teachers felt it was necessary to spend periods of time in the clinical area. Each of the participants had formal links with named units in the clinical area. Reasons for needing clinical skills were cited as personal development and in order

to enhance communication between clinical (practice) and teaching (theory) work. This finding was supported by work undertaken previously by Clifford (1995) and Nolan (1987).

The concept of 'partnership' between education and clinical areas was viewed as important and nurse teachers needed to be actively undertaking activities that enhanced this as illustrated below:

'Because the change in the NHS is now so rapid it's important that nurse teacher's keep ahead – not that you can know everything but at least you have recent experiences which you can relate to as opposed to out of date...' (Interviewee 1.1)

'I enjoy visiting the wards, seeing staff that I used to work with – I get a buzz that they may still know me and I hope believe in what we do as nurse teachers – what I'm trying to say is that its essential to keep good relationships with clinical staff and that the students see that too' (Interviewee 1.2)

Both complained that clinical time did not get enough emphasis. Interviewee 1.2 also stated:

'I don't have enough time for everything I want to do – so I don't get enough time in clinical practice so my clinical skills are lapsing which means I don't feel that I am always credible in class – both have worrying implications'.

Both added that in times of additional pressures such as teaching in the classroom, meetings to be attended and studying for courses as part of personal development this aspect of their role was neglected (Coad 1994). Interviewee 1.2 was studying for a higher degree and felt that the time spent undertaking this added to the stress as illustrated in the following extract from the interview:

'Unfortunately, nurse teachers do not speak out about clinical skills and credibility being as important as the other aspects of our role'.

Interviewer: 'Can you explain that a bit further?'

'Well, when I'm busy I always look in my diary and clinical time often gets pushed aside even though I'm passionate about it. Its not in my contract loudly enough so I worry about that with the merger into the university and now I'm studying for my degree its got even worse – I'm ashamed to say'. (Interviewee 1.2).

7.2.4. Future Role Attributes

Discussion took place surrounding the future role of nurse teachers in higher education institutions. It was found that both knew very little about how the merger into higher education would affect their role. Moreover, both teachers believed that the role would be '*largely the same as it has always been'*. Interviewee 1.2 however felt that nurse teachers would have to be '*more self-motivated as the teams we currently work in will not exist'*. She also felt that there would be more pressures to *'undertake research and publish which traditionally has not been part of our role – if nurse teachers have published in the past it's been quite a novelty but when we merge I think it will be an expectation'*.

Interestingly, the need for clinical skills in the future was emphasised in view of the proposed merger into higher education. Interviewee 1.1 stated the following:

'The only thing I am sure about this merger is that our clinical links and our clinical credibility will be low on the agenda in the university'.

7.2.5. Current cultural and organisational understanding

At Stage 1 both nurse teachers responded that they felt they understood the culture and organisation of College A. 'Key' phrases that were cited repetitively during the interview were recorded and are listed in Table 7.3. An illustration of their comments included:

'We all work together very much so ... we work in clearly defined teams and have managers for those teams – they direct us to a certain extent but everyone knows the job to do and gets on with it' (Interviewee 1.1).

'You learn both what I call the formal and informal rules on the job as often I have found in my career – but the structure is well defined – we all know who's in charge and who does what' ... 'The student programmes are also clearly mapped out – we look after a course or a branch programme but generally see them develop right to qualification' (Interviewee 1.2).

A number of key 'positive' attributes of current role in College A were identified. Interviewee 1.1 stated that she enjoyed *'seeing students develop and qualify'*, *'influencing clinical practice'*, *'the challenge of keeping up to date and change'* and *'ensuring effective communication pathways were utilised'*. Alternatively, Interviewee 1.2 stated that *'pushing myself to do better'*, *'working in collaboration with those in clinical practice'*, *'being a positive role model'* and *'supporting students as the progress along the routes offered to them'* was a positive attribute of the role. Alternatively, perceived problematic areas of current role in College A were also discussed. Interviewee 1.1 included:

'workload increases all the time – the more senior you become the more pressures there are' ...'there's not enough to keep myself up to date with all my other duties'...and *'the loss of clinical contact'.*

Table 7.3. Cultural & Organisational attributes of College at Stage 1

Key citation	Respondent 1.1	Respondent 1.2
Communication /'team' work (working patterns, hierarchy structure)	12	7
Meetings (Formal and informal)	8	11
Rules (formal, informal)	9	7
Management /Bureaucracy (Managers, authority,)	8	6
Administration (Paperwork, office work)	7	5
Student issues (Entrants, rights)	7	4
Clinical issues (links, liaison)	4	6
Teaching delivery (Expected classroom & clinical)	6	4
Curriculum (Understanding, delivery)	3	2
Educational developments (Development of organisation)	2	1
Research/Publishing (Understanding, expectation)	1	2
Academic support (Courses and study days)	2	2

7.2.6. Personal information about higher education

In preparation for the merger into higher education, both of the two nurse teachers stated that, besides knowing that the announcement had taken place of College A transferring into University A and some limited reading in the nursing press, they had not prepared themselves for the merger into higher education. Interviewee 1.2 felt she *'was ignoring it until it actually happens'*. As indicated earlier (Chapter 6) Hofstede (1994) suggests that this is a common reaction in 'merger events'. Interviewee 1.1 expressed concern what the future in higher educational institutions would bring:

'I don't know really know about the culture of how the university works – probably similarly ... I have heard there is less student contact as the philosophy of higher education is more focused on the independent, adult learner than probably the college is but its all heresay – I have no real idea if I am honest' (Interviewee 1.1)

7.2.7. Organisational higher education information

At Stage 1, both nurse teachers stated that they had had no specific preparatory information from College A or University A such as a letter or a lecture. Interviewee 1.1 had attended a course at University A so she felt that some of the university staff were already known to her. However, both believed that the nursing union representative at College A (Royal College of Nursing) was beginning to *'raise concerns about this issue' (Interviewee 1.2.)*. Interviewee 1.2 stated that a meeting of nursing unions was imminent and that she would attend. Neither participant claimed to feel *'stressful'* about the merger into higher education at this time although they knew some colleagues who were anxious.

7.2.8. Benefits of role in higher education

Despite the obvious lack of preparation and awareness about future role attributes it was felt appropriate to discuss the nurse teachers' perceived specific 'benefits and problems' of working in higher education. Key areas are represented diagrammatically in Table 7.4.

Interviewee 1.1 stated that she hoped her role would be more clearly defined and that she would be able to 'enjoy' more opportunities such as academic development and research opportunities. Her vision was that this would be '*like having a new job!* Additionally, Interviewee 1.1 commented that she envisaged improved library resources for staff and students. This originated from her experience of University A '*having been a student at the university, I do feel the library and student facilities were very good – well certainly in comparison to the college'.*

Interviewee 1.2 also felt that, as a result of transferring to University A, she would experience more self-development such as academic and research opportunities and improved teaching resources. As a consequence, she hoped that the culture of higher education would '*push me a bit more'*. She felt that this would evolve through the expectations of university staff and teaching requirements. Although she had not specifically prepared for the merger she was aware that staff had more autonomy and a '*more flattened structure which I am looking forward to'*.

7.2.9. Problematic issues of role in higher education

Expected problems and challenges of the nurse teacher role in higher education were also discussed. Key areas are outlined in Table 7.4 Interviewee 1.1 felt that there would be less clinical emphasis in the university stating,

'certainly as we know this role to be in the college – nurse teachers do need to move away from the bedside teaching model but at the same time we need to ensure we develop learners skills and monitor their progress and liase with clinical staff - I think there will be less of this in the university as time goes on'.

She felt that this would be the case because there were more perceived pressures such as personal development and larger group sizes of students. In addition, she used her experience of being a student at University A to state that the culture was very de-personalised; *'I think in universities staff may be less aware of nursing students in their own right and that will affect our role'*. Interviewee 1.2 reiterated some of Interviewee 1.1 concerns.

'I think the pressures to perform will be greater such as having to publish and research and keep up to date – surviving all this will be challenging but lonely mission'.

Table 7.4. Benefits and problems of nurse teachers working in higher education

Benefits	Problems
Interviewee 1.1. Role clarity More academic and research opportunities Improved Resources	**Interviewee 1.1.** Less clinical emphasis More pressures such as personal development Larger group sizes De-personalisation
Interviewee 1.2. More self development and autonomy Change to academic levels and modes of teaching Improved teaching resources	**Interviewee 1.2.** Increased pressures to publish and research and keep up to date

7.3. Student Nurses

This section summarises the findings of two female third year student nurses from College A who were asked questions about their perceptions of the nurse teacher role and how they saw the merger of nurse education into the university would affect the role (Interviewee 1.3 and 1.4).

Both stated that they used the title 'Nurse Tutor' (or their first names) and did not envisage any changes after the merger into higher education. The current role of nurse teachers was outlined and included teaching in the classroom, reading and supervision of assignments in tutorials, support issues and organisation of their courses and placements. Time visiting the student nurses on placement was discussed. One stated that she had been visited twice by a 'tutor';

'a tutor came out to see me which was very nice in one of the hospitals which is quite far away from the college and one came over the road as the college was opposite – I have also gone over the road several times to see tutors to show them my work – its very handy being so near' (Interviewee 1.3).

The other stated,

'I've never seen a tutor on placement although I think we are supposed to – I see them in college and in the classroom but nothing else so far really' (Interviewee 1.4).

Both student nurses understood that soon College A would *'go into the university'* although neither was aware of any specific details. Both felt that this would be positive for nursing as this would lead to higher qualifications and improved facilities for students who would experience courses alongside other professional

groups. In discussion about perceived benefits and problems for the nurse teachers' role in higher education the immediate responses were;

'I'm a bit unsure of this – I mean I don't really know what they do beside what I've said so I'm unsure how this will change' (Interviewee 1.3).

'Will there be any change in the nurse teachers role? I've never thought about it - but I have heard that student numbers will be going up – It makes me glad actually to have trained when I did – the group I am is 25 and we all know each other really well and even though the tutors are busy you can get appointments .. and we have good placements – it would be awful if the group sizes go to what they are rumoured to – I have heard this will be up to 100 – that's terrible!' (Interviewee 1.4).

This was interesting data highlighting a potential lack of awareness about the impact of the merger into higher education on the nurse teachers' role.

7.4. Clinical Nurses

This section summarises findings of two clinical nurses (one female and one male) from Hospital A (Interviewee 1.5 and 1.6).

Similar answers to the student nurses were elicited from the two clinical nurses. They both stated that they understood very little about what the nurse teachers' role really was, only what they had experienced as students themselves and from seeing them around the hospital whilst they worked in clinical link roles. A recurring theme was the lack of contact with nurse teachers from College A although both felt that this was because 'heavy workloads' prevented this contact. These findings are congruent with previous work by Crotty (1993) and Clifford (1995a). Comments included:

'We see them at audits when they have to visit the ward and when there's a problem and occasionally in between – I think it should be more but I appreciate its difficult' (Interviewee 1.5).

'They used to be more active but since the demise of the clinical teacher it's sporadic. It will be interesting to watch what happens once nursing is in the university – I am able though to just go over and see any of them as our college is opposite where we work but I am rather concerned that the university is a mile away – I won't be popping down there like I could now' (Interviewee 1.6).

Both clinical nurses advocated that nurse teachers should spend time on the wards/clinical areas developing in order to bridge the 'theory / practice gap'. Interviewee 1.5 stated:

'that although they are very nice when you see or speak to them actually I think they are often out of touch with the reality of practice' (Interviewee 1.5).

Interestingly, the impending merger into higher education was not thought to have any significant effect on 'clinical link' role (Chapter 3). Moreover, both were unclear as to how this role would develop with the merger into higher education but continued to stress the need for even better links. One stated:

'We can't see it now but come back a year after the merger and the impact of nursing in the university will have hit us I hope – we will know more then (or possibly less!) but I should think that is then that you could really evaluate the advantages and disadvantages of nurse training being in higher education' (Interviewee 1.6).

7.5. University Lecturer

This section summarises the findings of one female who had worked for University A as a Principal Nurse Lecturer (Interviewee 1.7).

Interviewee 1.7 was very positive about the forthcoming merger of College A into University A. However, she was aware that some colleagues had anxieties about what this would mean to existing staff's role in the faculty of University A. She was also very clear about her role in the university and stated the following attributes:

- Facilitator
- Researcher
- Lecturer
- Autonomous
- Flexible
- Consultant
- Academic
- Change agent
- Positive role model

Throughout the interview although 'practice' was related to students, no mention was made to having a university nurse lecturer role that should link theory to practice or have 'clinical links'. The views of one person cannot be used to make generalisations from but is interesting to note this difference from the previous

transcripts of nurse teachers and clinical staff (and given the previous literature about the importance of this role to nurse teachers).

The perceived advantages and disadvantages of nurse teachers merging into the university from College A were discussed. The discussion is outlined in Table 7.5.

Table 7.5. Benefits and problems of nurse teachers working in higher education (University Lecturer)

Benefits	Problems
Improve research awareness	Change to mode of teaching
Greater networking opportunities	Less clinical emphasis
Role clarity	More pressures on personal development
More academic development	Change will be source of anxiety and stress
Greater publication opportunities	Managerial structure change
More autonomy	Different culture
More flexibility	Big culture shock!
Different pace/culture	
More consultant work	

The following extract illustrates also one of Interviewee (1.7) views on the transition of nurse teachers merging into University A:

The nurse teachers, some of which I know personally, are in for a shock I'm afraid – it will interesting to record it all but when I came from the school of nursing as it was then – it was certainly a big culture shock'

Interviewer: What do you mean by 'a big culture shock'?

'Well, the advantages of university of life outweigh the disadvantages but it takes a while to adjust – the pace appears more relaxed – less controlled but actually you do more work – there's no bosses as such so you have to be very motivated and the students are a different breed so you have to be more flexible and less controlling'

...'The nurse teachers transferring will also be part of large university, not just a small nursing college so it will be a big shift for some of them but a good thing I believe'

'Also development of yourself is crucial – they will have to be much more political beings and more self-driven – there are lots of opportunities to grab in university life but only YOU can grab them – I think this will be good for the nurse teachers but terrifying at the same time!'

7.6. Summary of Stage 1 Findings

In summary, the purpose of Stage 1 was to analyse the emerging data in order to develop the interview tools for the longitudinal study and develop the framework from which further data analysis could take place. In essence, this aim for this stage had been achieved, as it was beneficial to have interviewed a range of the groups associated with nurse teachers to 'get a feel for their views'. Following the Stage 1, pilot work, two interview schedules were designed, one for the nurse teacher group at Stage 2 (Appendix 8) and one for the clinical nurses at Stage 3 (Appendix 9).

Overall, the sample was very small, but findings demonstrated that the nurse teachers were aware that the merger of nurse education into HEIs was a positive development for nursing. Conversely, an interesting issue was the nurse teachers' lack of preparation about the culture and organisation of HEIs generally, as well as specifically, in relation to the university that they would be ultimately transferred into. It was evident that they were aware that their titles and role attributes would change, but how, was unknown at this time. Arguably, these issues identified at this stage were a concern, as potentially this lack of preparation could affect the adjustment to role and could increase the likelihood of a 'culture clash'.

It was also beneficial to interview the student nurses, the clinical nurses and a university lecturer at this stage. Their views helped to inform the subsequent longitudinal study and reiterated the emerging theme that the merger into higher education was viewed as a positive development in nursing. It was, however, clear

from the findings that overall they understood very little about how this would affect the nurse teacher role. This may be in part due to the limited understanding about the nurse teacher role. Roper and Shapira (2000) support such an approach at the preliminary stage but warn against too much diversity of views in the main part of a study. This was noted in the study reported here. Therefore, the decision to narrow the focus at Stages 2 (nurse teachers), and Stage 3 (clinical nurses) was substantiated.

Chapter 8

Stage 2 Findings

8.1. Introduction

The purpose of Stage 2 was to explore role perceptions of fifteen nurse teachers as they moved from working as nurse teachers in colleges of nursing in the NHS into 'Nurse Lecturers' in HEIs. A semi-structured interview schedule (Appendix 8) was used prior to, at and one year after the merger into higher education (Stages 2a, 2b and 2c respectively) as indicated in Table 8.1. below:

Table 8.1. Stage 2

In-depth exploratory interviews of a group of 15 nurse teachers using a longitudinal interviews (x 45 interviews):
Stage 2a: Three months prior to the merger into higher education when the nurse teachers were employed within one college of nursing in the NHS
Stage 2b: At the 'merger point' from one college of nursing in the NHS into one HEI.
Stage 2c: Twelve months after the merger into one HEI had occurred.

This chapter presents the findings at Stage 2 as a result of the analysis described in Chapter 6 (Section 6.10). As with presentation of Stage 1 findings (Chapter 7), direct quotes are presented using italics followed by each participant's code *(Interviewee 2a.1 to 15)*. The numbers in each table refer to the number of times a 'key' phrase was used.

8.2. Nurse teachers PRIOR to the merger (Stage 2a)

This section summarises the overall responses from eleven women and four men, who were nurse teachers three months prior to the merger into higher education when the nurse teachers were employed within College A in the NHS.

8.2.1. Current job title/preferred title

Hofstede (1991) suggests that titles are important in the workplace as they help employees to understand their place in the organisational structure. All of the nurse teachers interviewed identified that they anticipated a change of title as a consequence of the transfer into higher education. Eleven of the nurse teachers described themselves as 'Nurse Tutors' and four of the group stated that they were 'Nurse Teachers'. No participant was in any doubt about the title (Table 8.2.). This was an interesting perception supporting Luker et al (1993), who found similarly that nurse teachers in colleges of nursing could clearly identify their job titles.

Table 8.2. Perceived job title at Stage 2a

Job Title	Responses
Nurse Teacher	4
Nurse Tutor	11
Nurse Lecturer	0
Senior Lecturer	0
Unsure	0

8.2.2. Career Plan/biographical profile of nurse teachers

Career plan was identified as important background information from the Stage 1 interviews. All of the nurse teachers had worked in nurse education for a minimum of two years up to fourteen years and were in the age range of 30 to 42 years. All had commenced a career in teaching after gaining considerable clinical experience within the nursing specialities of general/adult, mental health and paediatrics. Total clinical nursing experience ranged from six to nineteen years of service. All 15 had been in positions of leadership and autonomy before entering nurse education including, for example roles of Ward Sister or Charge Nurse level. Since then all of the nurse teachers had also gained teaching qualifications, although 13 had worked as 'Unqualified Nurse Teacher' prior to obtaining their teaching qualifications.

Reasons for choosing nurse education as a career were explored and multiple responses are outlined in Table 8.3.

Table 8.3. Reasons for choosing nurse education as a career (Stage 2a)

Reasons given	Responses
Self Development	12
Worked as unqualified teacher	13
Enjoyed teaching	10
Positive Role Model/Influence nursing	9
Opportunity of academic development	6
Advised to	5
Convenient hours	3
Better pay/contract	2

These categories are expanded in the following responses:-

'I felt that in coming into nurse education I would get the academic challenge that I needed' (Interviewee 2a.4)

'I enjoyed teaching the students on the ward so it seemed right to do it when I did' (Interviewee 2a.7)

'I was advised by our link tutor – but if I'm honest I just seemed to be in the right place at the right time' (Interviewee 2a.13)

All the nurse teachers were delivering programmes at level 1 and level 2 (diploma) work. None taught on any degree courses. Nine were solely responsible for pre-registration courses whilst three were responsible for post-registration students and three taught across both types of programmes. Nine of them viewed themselves clearly as 'specialists' within their area of nursing including adult (critical care, elderly care) paediatrics, mental health and community. They stated that since the advent of Project 2000 (UKCC 1986) and Post Registration Development work there was increased health focus to the curriculum, which included a greater emphasis of the sciences of physiology, sociology and psychology. Seven of the nurse teachers also identified that as part of the educational changes they had also experienced altered teaching commitments. Examples included the teaching of 'ologies' i.e. sociology, biology and psychology or research. Moreover, participants identified that such teaching responsibilities had been encouraged by College A management as part of their preparation for the merger into higher education. This reflects Luker et al's (1993) findings where it was noted that specific 'ology'

teaching had been allocated out to teachers in preparation for the move into higher education.

Interestingly, preparation to teach in specialist areas caused concern. Whilst three stated that they taught subjects which they had studied in their first-degree studies, such as psychology, others felt that some of the subjects they taught, such as research, did not reflect their expertise. Four nurse teachers stated that they had been deemed as 'experts' with little preparation. All four also stated that they felt this might impact on their career plan and that they would have preferred more choice about these new teaching commitments as highlighted in the following response:-

'I have just completed my degree which I wanted to do but felt a certain amount of pressure to do now with the merger over our heads. What was really annoying was on my return I found that I had been given the teaching of mostly physiology which I do enjoy but would not consider myself an expert at' (Interviewee 2a.10)

Prior to teaching in specialist areas nurse teachers did identify that teaching had been based on a 'jack of all trades' approach. This was highlighted earlier by Buttigieg (1990), who found that the nurse teacher role was so multi-faceted that preparation for teaching and subsequent responsibilities was often *ad hoc.*

8.2.3. Current Role attributes

A description of current role attributes was useful in ascertaining the nurse teachers' perceptions of the required attributes of their job at the time of each interview.

These are presented prior to the merger in Table 8.4 using the literature previously outlined (Chapter 3), to organise five 'common' role attributes into groups entitled classroom role, student role, clinical role, managerial /administration duties and personal role attributes. Each section will be dealt with.

Table 8.4. Identified current role attributes prior to the merger at Stage 2a

Key group attributes identified in literature	Specific attributes identified in the study	Multiple 'key phrases' identified (n =)
1. CLASSROOM ROLE	Development of students (classroom)	15
	Teaching skills	10
	Link theory to practice (Classroom)	9
2. STUDENT ROLE	Communicating with students	15
	Supporting/counselling students	8
3. CLINICAL ROLE	Communicating with clinical staff	15
	Nursing expertise	15
	Linking theory to practice (Clinical)	12
	Clinical credibility	12
4. MANAGERIAL/ ADMINISTRATION ROLE	Administration/managerial – marking, correspondence, meetings and course organisation	9
5. PERSONAL ROLE ATTRIBUTES	Communicating with colleagues	14
	Communicating with senior managers	14
	Academic experience	11
	Positive role model	6
	Adaptation skills	3
	Motivation	3
	Questioning skills	2
	Autonomy	2
	Networking	1

8.2.3.1. Classroom role

As indicated from Table 8.4, classroom role included the development of students (15/15), teaching skills (10/15) and the linking of theory to practice (9/15). All the nurse teachers felt the amount of time in the classroom was 'about right'. The level of enjoyment of classroom role was explored, with the most citing reasons related to the development of students. This finding was also noted by Clifford (1993a) who found that student development was seen as a reason for enjoyment in the classroom role. This contrasted to the nine responses related to linking theory to practice in the classroom, where views expressed included 'frustrating' (2/15) and 'difficult' (3/15), and some noted that teaching larger student numbers could limit group interaction (4/15). Further attributes identified for discussion related to the required teaching skills of nurse teachers. Ten felt that teaching skills were essential to perform the role and that;

'nurse teachers need to have time and support mechanisms in place to develop their classroom role' (Interviewee 2a.6)

8.2.3.2. Student Issues

Data presented in Table 8.4 shows that communicating with students including supporting and counselling them, are important role attributes of nurse teachers. All fifteen of the nurse teachers stated during the interview that student communication was crucial to them. Eight felt that more time was needed to fully utilise their communication strategies in order to support and counsel students effectively (8/15).

This is illustrated in the following quote:

'I really enjoy helping to develop students – I have had personal students that I have seen develop from the beginning to the end of the course and I love that – I love watching them develop – becoming more confident and then finally ... it's a real buzz to see them at graduation – but it's a question of having enough time to do this' (Interviewee 2a.14)

8.2.3.3. Clinical Role

The specific attributes identified included communicating with clinical staff (15/15); nursing expertise (15/15); clinical credibility (12/15) and the linking of theory to practice as part of the clinical role (12/15) (Table 8.4). Fifteen nurse teachers felt that nursing experience and expertise was essential in order to perform the role. This reflected the findings reported at Stage 1 of the study reported here and in the work of Clifford (1995a). Comments included:-

'Oh ...definitely my nursing background is essential- it helps me with the clinical contacts that I have and I use examples in the class to help the students understand' (Interviewee 2a. 1)

'I feel that my nursing experience is crucial to the role but we rather take it for granted that we need it so much for this role' (Interviewee 2a. 8)

'Nursing is for me far more important than any other aspect as how can you be credible in class if you have not got nursing experience ... so I think you need to have several years of nursing experience before performing this job' (Interviewee 2a.12)

As part of the clinical role all 15 of the nurse teachers also performed 'a link' role with specific areas/units in a variety of specialist settings. This meant that they were the named representatives to visit a specific ward, department or unit within the hospital or community placements (Chapter 3). Whilst on the visit some nurse

teachers used this as an opportunity to discuss nursing issues or student problems. Although 15 were the 'named link' seven stated they were not performing any 'active' aspects of a clinical role such as working alongside students caring for patients. Nine of the participants also reported on the confusion about the length of time spent in the clinical areas and what this role entailed when they actually did visit the link wards or units. Comments included:-

'I do link to four wards actually but I am always unsure what I'm supposed to be really doing when I get there and sometimes I wonder if clinical staff and students actually benefit from the role' (Interviewee 2a. 15)

'I do feel its a useful role as communication with the clinical staff is vital to the development of the courses and the students and keeps us in touch with what's going on ... but its not really developed or clear what we are supposed to do when we get there' (Interviewee 2a.8)

As indicated in Table 8.4 (page 254), twelve nurse teachers felt that linking theory of nursing to the practice was an important part of clinical role attributes and that the link role was essential in ensuring that nurse teachers had 'clinical credibility' (Chapter 3; Section 3.4.2). However, whilst all the nurse teachers stated that they were linked to a speciality ward or unit which they appeared to be qualified in, for example, general, mental health or paediatric nursing, only six felt that this was the case. The remaining nine felt that they did not have the clinical experience to be linked to the ward/unit that they were linked to, such as Accident and Emergency and Theatre Departments.

One lecturer who had worked for several years in Operating Theatre departments and had very little ward experience found that she was 'linked' to a medical specialised ward. She commented:-

'There was no-one else offering to do it and theatres had already got a named link so I thought about it and decided it might be good for me' (Interviewee 2a.2)

When asked if she felt confident about the link area:

'No, not really but you have to have a link to be seen as credible and as I only visit students anyway it's their needs I am looking at not my nursing care skills'

Another teacher whose background was acute mental health care was linked to long stay and elderly wards, whilst a further teacher in paediatrics was linked to a children's specialist surgical ward when her background was chronic medical wards. She stated:-

'I am unsure how I ended up linked with this ward - perhaps I was off on the day when the wards were being distributed!' (Interviewee 2a.15)

8.2.3.4. Managerial and administration role

Specific attributes identified of administration and managerial duties (9/15) included marking, correspondence, meetings to be attended and course organisation dominated the role (Table 8.4). Two of the nine added that as a consequence the nurse teacher had to be very autonomous in their work. This was also found in the studies reported by both Nolan (1987) and Clifford (1995) where nurse teachers indicated a high level of dissatisfaction due to the large amount of administration

duties. None of the nurse teachers in the study reported here 'enjoyed' this part of the role, all citing that it took them away from other more valued aspects of the role. Lack of resources, including secretarial help or computing facilities was also noted as a common problem. One participant related the problems to the college organisation stating thus;

'The organisation is immense - the courses, the letters, the clinical link issues, the meetings and decision making all add up to a very demanding job...but I do feel that this is not the nurse tutors being inefficient but rather the hierarchical structure of the college itself ' (Interviewee 2a.11)

Interviewer: Can you explain that further?

'Well, I just feel we have got so caught up in little rules and lots of managers that we have lost the essence of what we are supposed to be doing. I'm sure some of the things I do in my day to day role could be done by good secretaries or good personnel and certainly less managers'

Other comments included;

'I do not have enough time to do all that is expected from me so most days I suppose I get by' (Interviewee 2a.9)

'Its actually the most stressful job I have performed and I think this is because of all the managerial commitments I have' (Interviewee 2a.12)

'I'm sure people imagine its a fairly easy job but its not - the responsibility of guiding students development, of teaching, of attending meetings e.t.c. e.t.c. .....and keeping up to date and being dynamic is very hard' (Interviewee 2a.5)

8.2.3.5. Personal attributes

The specific personal attributes teachers cited were academic experience; communication with colleagues and senior managers; being a positive role model; using adaptation skills; being motivated; possessing questioning skills; being

autonomous and having networking skills (Table 8.4). In exploring this more closely, eleven of the nurse teachers felt that personal academic experience was essential to the role. All fifteen had a range of academic and professional (nursing) qualifications and all had undertaken teacher preparation courses at various higher education institutions. Thirteen already had a first degree whilst the remaining two were completing these. Three nurse teachers had a Masters degree, whilst two others were in the process of registration for this. No other higher degrees were held. The reason given for undertaking a degree was partly due to the changes in professional requirement outlined elsewhere (Chapter 4). Of the 13 who had their first degree at this stage none regretted undertaking a degree, although four participants wished they had undertaken a different option. Preferred examples included a specialist focus such as psychology or social sciences, which they felt would have help them in their future role in higher education. Preferred specialist focus by nurse teachers was also highlighted in the work of Luker et al (1993). This is exemplified in the response:-

'Although my teaching qualification gave me some skills and confidence I wish it had given me more preparation about the role and help me adapt to change better than I do especially with the transfer into higher education' (Interviewee 2a.3)

All the nurse teachers felt a further important role attribute was possessing 'good' communication skills with colleagues, senior managers, students and clinical staff and six felt that a positive, strong personality was useful (Table 8.4). These findings are supported by Eason and Corbett (1997) who found that 'effective teacher

attributes' such as personality contributed significantly to perception of nurse teacher role. Additional specific attributes included having adaptation skills (3/15), being motivated (3/15), possessing questioning skills (2/15), being autonomous (2/15) and having good networking abilities (1/15).

8.2.3.6. Most important and worst aspects of the current role

A further key area explored was perceptions of the 'most important' and 'worst' aspects of the current role, each participant having only one choice (Table 8.5). Nurse teachers felt that the most important aspect was delivery of quality nursing courses (5/15), to develop and support student nurses (4/15), use effectively communication pathways (3/15), having nursing and teaching experience (2/15) and possessing a strong personality (1/15).

Table 8.5. Most important versus worst aspects of role at Stage 2a

Most Important	Responses	Worst Aspects	*Responses*
Course delivery	5	Diversity of demands	9
Student support/development	4	Lack of time	4
Communication strategies	3	Meetings	2
Nursing/teaching experience	2		
Personality	1		
	(Total = 15)		*(Total = 15)*

One comment is included:

'The most important role attribute? Well, for me it's my personality which I use to talk and listen to the students and colleagues ...and if I can put in another with personality it would be my sense of humour which has got me through lots of difficult or stressful times (Interviewee 2a.14)

The 'worst' aspects of the role at Stage 2a included the diversity of the demands of the role (9/15), the lack of time to undertake all the required aspects of the role (4/15) and the meetings to be attended (2/15).

8.2.4. Future Role attributes

Questions relating to expectations about the future nurse teacher role in higher education after the transfer were interesting (Table 8.6), especially in comparison to their current role as previously presented.

Table 8.6. Expected Future Role Attributes in Higher Education at Stage 2a

Future Attributes	Responses
Academic Qualifications	13
Research & Publishing	6
Nursing Expertise	4
Teaching skills	4
Unsure	4
Theory/Practice skills	3
Networking Skills	3
Adaptation Skills	2
Autonomy	1

Four felt that nursing expertise would be required, whilst, on prompting, the other eleven stated this would not be required. Three of eleven, however, felt that linking theory to nursing practice would be required as a future role attribute. Thirteen nurse teachers felt that academic qualifications and expertise would be future attributes and six also felt that research/publishing activities would be essential. The following comments illustrate this:-

'I feel that we will be expected to drive forward a more academic culture to nursing and so in turn will also need to develop ourselves more and publish more' (Interviewee 2a.1)

'From what I have heard I believe that the philosophy is very different in that research will play a greater part which I suppose is bound to affect our teaching style and pressures upon us' (Interviewee 2a.5)

Nine of the nurse teachers stated that they found this line of questioning difficult at this time, as they were actually unsure as to the expected future role attributes. Clifford (1995) found similar findings with respect to the expected research role of nurse teachers. None of the participants in this study had experienced working in higher education previously although they had been students themselves. The following extracts illustrates this point:-

'I have to be honest - I'm really unsure about what role is expected of us - I hope it would be a nursing expert but on a day to day basis. I just get on with my job and wait for it all to happen' (Interviewee 2a.3)

'Unsure really – I hope to preserve my expertise in the teaching I do but who can say? (Interviewee 2a.11)

8.2.5. Current Cultural and Organisational Understanding

As the purpose of the study was to record the nurse teacher role it was important to ascertain the nurse teachers' understanding of current cultural and organisational attributes. They were asked to identify three attributes considered to be fundamental to the working of the college of nursing that impacted on their current role. All of the fifteen nurse teachers were sure of the college cultural and organisational attributes and each were able to easily identify three with responses falling into four categories. These responses are summarised in Table 8.7, but included rules both formal and informal, internal and external communication pathways, administration and bureaucracy, and expected delivery and developments.

Table 8.7. Key cultural and organisational attributes of College A at Stage 2a

Participant	Rules	Communication	Work Organisation	Curricular - Developments
1.	Rules clearly defined	Team work allocated by head	Hierarchical system of secretaries, teaching and management	
2.		All work together but in own teams	Clearly defined organisation of work useful	
3.	Formal and informal rules – not flexible	Hierarchical and restrictive management		Clearly defined curricular development and delivery
4.	Flexible work rules with clear expectations	Hierarchical leadership	Meetings and Administration high due to management	
5.	Clear formal systems. Informal not understood	Hierarchical leadership in clearly defined teams		Curricular development purposeful & helps staff to develop courses

6.	Rules of staff and students clearly defined	Largely hierarchical system		
7.	Clear understanding of rules relating to both classroom and clinical role		Clear management structure helps clear organisation of work	Clear structure in courses development (student-centred)
8.	Understand rules in terms of classroom and clinical delivery		Understand organisation of work but time is wasted	
9.		Strong emphasis on clinical links within team work	Hierarchical system of secretaries, teaching and management	Academic development of staff clearly defined
10.	Formal and informal rules but all are inflexible	Working patterns in teams result in definite communication pathways	Meetings and Administration high due to management structure	Curricular development in organisation is slow
11.		Clear team management and lines of authority	Paperwork and administration high	
12.	Formal rules well understood	Hierarchical leadership		Curricular developments can be restrictive
13.	Rules of staff and students clearly defined	Clear lines of communication All work together but in own teams		
14.	Staff and student rules historical and well accepted		Meetings and administration duties are high	Curricular development clearly defined
15.	Good understanding of rules	All work together but in own teams to deliver nursing theory to relate it to practice		Slow, very tedious course development

A theme of 'formal and informal rules' was identified in twelve of the transcripts and several of the nurse teachers used these key phrases (Table 8.7). As highlighted previously (Chapter 5) where 'formal' and 'informal' rules are central to the culture of an organisation they may serve to 'control' the staff in the organisation (Handy 1993, Hofstede 1994). It appeared from the twelve transcripts that ten understood and 'wanted' the formal and informal rules of College A, whilst two understood them but felt these rules were 'inflexible' and 'restrictive' (*Interviewees 2a.3* and *2a.10*).

A recurring phrase related to communication pathways within the structures of College A. Eight nurse teachers referred to a positive team work structure but with well-delineated 'managers' who work together to *'deliver nursing theory to relate it to practice' (Interviewee 2a.15)*. On the other hand, five transcripts referred to the leadership structures as *'hierarchical'*, which was viewed as problematic (*Interviewees 2a.3; 2a.4; 2a.5; 2a.6* and *2a.12*). Such patterns were identified in the previous organisational culture work of Sackmann (1991) and Handy (1993) (page) and studies in nurse education such as Luker et al (1993) and Clifford (1995).

The organisation of work with respect to administration and bureaucracy of College A was also discussed (Table 8.7). Nine of the participants used phrases including that there was a *'hierarchical system of secretaries, teaching and management'* (*Interviewees 2a.1* and *2a.9*) and that this was felt to '*high*' due to the management structure (*Interviewees 2a.4; 2a.10; 2a.11* and *2a.14*). Alternatively, others felt that

the clear management structure was helpful and lead to clear organisation of work with respect to administration and bureaucracy (*Interviewees 2a.2* and *2a.7*). Interviewee 2a.8 felt that that whilst they understood the organisation of work and that this was useful much time was wasted. Curricular development and delivery was also noted to be part of the 'culture' of College A (Table 8.7). This was felt to be clearly defined with a clear purpose to develop staff and students in five transcripts (*Interviewees 2a.3, 2a.5, 2a.7, 2a.9* and *2a.14*). However, three nurse teachers felt that curriculum development was slow and restricted by rules (*Interviewees 2a.10, 2a.12* and *2a15*).

8.2.6. Personal information about higher education

As part of the projected nurse teacher role attributes, preparation for the merger at an individual or 'personal level' was explored. All the nurse teachers felt that, whilst the merger of nurse education into higher education was a positive move, little personal preparation had occurred. Largely communication was orchestrated through other college staff as evidenced in the following response:-

'I have learned most of my information from my colleagues which is learned from other colleagues – somewhere the truth is in there but much of it is gossip!' (Interviewee 2a.8)

Five nurse teachers stated that they had met with union representatives at the college and had found this particularly useful in preparing them for the merger event and their subsequent role (Table 8.8). Four responded that they intended to use their own experiences of being a student at university, two of which had been

students at university A. In addition, one cited that she had contacted staff from university A to '*get the low down on how they all felt' (Interviewee 2a.3).*

Table 8.8. Personal preparation for the merger into higher education at Stage 2a

Preparation used	Responses
Communication with college staff	15
Direct Communication with union representatives	5
Utilisation of own experience (research/academic courses)	4
Communication with university staff	2

8.2.7. Organisational information about higher education

As part of the background information about nurse teacher role in higher education, organisational preparation was explored. All the nurse teachers had had some type of informal meeting with their line manager and/or teams within the college of nursing at this stage (Table 8.9). Four had attended a 'formal' union meeting organised at an external event to the college and were aware with other participants of impending union meetings to be held internally at the college of nursing. All stated that they intended to attend.

Correspondence had been received by all the nurse teachers from the college of nursing about the merger, whilst none had been received from the university. This concerned several participants in their responses:-

'It feels a bit strange because it's like a monster lying in wait – its there ready to eat us up and yet we know nothing about it!' (Interviewee 2a.1).

A total of nine of the nurse teachers felt that information giving was the responsibility of the university and that the college was being *'taken over'* in some way. This was supported by Sackman (1991) who noted that during cultural events such as mergers staff feel powerless to control events.

Table 8.9.
Organisational preparation about the merger into higher education at Stage 2a

Organisation Preparation	Responses
Informal meetings (Manager/Teams)	15
Correspondence (from College)	15
Formal meetings (College of nursing/union)	4
Correspondence (from university)	0

8.2.8. Benefits of role in higher education

Nurse teachers were asked to identify three perceived benefits of working in higher education in order to build up a picture of perceptions and expected role. Perceived benefits included facilitation of developing the professional base of nursing (15/15), an increased job status in working for a university as a lecturer (9/15) and self development (9/15) (Table 8.10). Responses also indicated a strong feeling that as a result of the merger lecturers would need to publish or be involved with research activities more than they had previously (6/15) and an increase in the need for academic development of staff (6/15) (Table 8.10).

'It's frightening but I think in the long run it must do us all good – sift out the dead wood and bring a new face to nurse teaching delivery' (Interviewee 2a.6)

'I never thought when I went nursing all those years ago that I'd end up here – its quite exciting thinking I'm going to be a university lecturer – well my mum's pleased anyway! (Interviewee 2a.10)

Table 8.10. Perceived benefits of working in higher education at Stage 2a

	Responses
Develop professional base of nursing	15
Increased 'job' status	9
Self personal development	9
Research / publication development	6
Further academic development	6

8.2.9. Problematic issues of role in higher education

Perceived problematic issues of the nurse teachers' role in higher education were also explored, despite the lack of preparation for the merger that nurse teachers appeared to have had at this stage. At this stage participants re-iterated concerns for the potential loss of clinical skills (15/15) and the perceived consequences of this, such as a perceived wider theory / practice gap (9/15) (Table 8.11). It was interesting to record that respondents felt that as a result of a change of organisational structure (7/15) and increased research/academic pressures (4/15) these would act as a source of increased stress (7/15) as illustrated in the comments below:-

'I am worried that there may be less clinical developments such as the clinical link role disappearing and as a consequence my clinical credibility' (Interviewee 2a.4)

'I think – and it's really think that you are on your own a lot more and that may be problematic in a role which needs collaboration for all sorts of reasons – the students being top of the list' (Interviewee 2a.13)

Table 8.11. Problematic issues of role in higher education at Stage 2a

	Responses
Loss of clinical/nursing skills	15
Wider theory / practice gap	9
Change of organisational structure	7
Increased role demands/stress	7
Increased research/academic pressure	4
Lack of managerial support	2

8.3. Summary of Stage 2a findings

At Stage 2a the emerging data from the nurse teachers interviewed highlighted a multi-faceted role congruent with literature explored in Section 2.3 including Davies et al (1996), Gerrish (1992), Cahill (1997), Clifford (1992, 1993, 1995 & 1999), Luker et al (1993) and Camiah (1996). At this stage some of the themes noted in the literature about nurse teacher role appeared to link to findings of the study reported. These included:

- Classroom Role
- Student Issues
- Clinical Role
- Management / Administration
- Personal attributes

There were also several key cultural and organisational cultural issues to note. Some of these included rules, communication networks, work organisation and curricular developments. Others included a lack of understanding between the current culture of College A, which they understood clearly, and the perceived future role attributes in University A. Therefore, data at this stage, suggested that the nurse teachers were ill prepared for the 'merger event', which was to take place three months after the interviews were undertaken. This was at both a personal and organisational level by University A, although information had begun to emerge from College A to prepare staff.

Some examples were notable. One related to the given titles of the nurse teachers as it appeared that, whilst the nurse teachers had well-established titles, they expected a change in title as they moved from College A into University A. Also, whilst nursing expertise had been cited by all fifteen as a current role attribute in College A, only four felt that this would be required in University A.

The future role attributes data also appeared to link to the envisaged benefits and problems of the role in higher education. For example, whilst benefits included developing the professional base of nursing, increased job status and the need to undertake more academic activities, publishing and research activities there were concerns that as a result, this would increase 'work pressures' and associated stress. Sackman (1991) refers to such attributes as '*untested assumptions*'. These are explored further in Stages 2b and 2c of the study reported below.

Stage 2b findings

8.4. Nurse teachers AT the merger (Stage 2b)

This section summarises the findings of fifteen nurse teachers at the 'merger point' from College A in the NHS into University A. Interviewees are identified as *2b.1 to 15.*

8.4.1. Current job title/preferred title

Eleven of the 15 nurse teachers highlighted current confusion about their titles and that they used several titles inter-changeably. For example, several nurse teachers referred to themselves as both Nurse Tutor and Nurse Lecturer although they were all later awarded 'Senior' or 'Principal' Lecturer positions in University A. During the interview one participant used the title *'Nurse Tutor'* on eleven occasions, *'Nurse Teacher'* on four occasions and twice she stated that 'she might be a '*Senior Lecturer'* or '*Nurse Lecturer'* but that *'no-one had told her' (Interviewee 2b.8).*

Each participant was invited to state his or her title 'preference' (Table 8.12). Eight responded as 'Nurse Tutor', two preferred that of 'Senior Lecturer' and one stated 'Nurse Teacher'. Four stated that they were actually 'unsure' as to what their title was and so felt that they could not answer

Table 8.12. Preference of job title at Stage 2b

Job Title	Responses
Nurse Tutor	8
Unsure	4
Senior Lecturer	2
Nurse Teacher	1

Interview extracts cited below indicate feelings at this time:-

'I could be a nurse lecturer or still a nurse tutor – I am very unsure about it all which I feel does affect my work – I feel very disappointed that this was not organised before we came in – after all they knew we were coming!' (Interviewee 2b.15)

'I have been told our contracts are still being discussed as they don't know what title to give us and where to grade us which I feel after all our nursing experience and qualifications is a bit insulting' (Interviewee 2b.13)

Several nurse teachers indicated that they were hoping to be accepted as 'lecturers' within the university:-

'I still call myself a nurse tutor but actually I'm hoping we get offered some sort of lecturer contract – its very much up in the air I believe' (Interviewee 2b.6)

A lack of clarity about the nurse teacher's title resulted in feelings of uncertainty, phrases of which are illustrated in Table 8.13. Data indicated that the lack of title clarity impacted on the lack of role clarity. Other comments related to increased anxiety levels (8/15), a need to 'prove' themselves in the new organisation (5/15) and a feeling of powerlessness (4/15). Such findings are outlined in the work of Hofstede

(1991) who suggests that any loss of identity could increase stress levels and a sense of powerlessness.

Table 8.13. Participants feelings about the lack of title clarity at Stage 2b

Thematic feelings	Responses
Unclear of role attributes	10
Increased Anxiety	8
Needing to prove self	5
Powerlessness	4

8.4.2. Career plan/biographical profile of nurse teachers

All nurse teachers were delivering nursing programmes at academic levels 1 and 2 (i.e. diploma certificate) which was no change from the data collected at Stage 2a. Nine were largely responsible for pre-registration work, whilst three remained responsible for post-registration work. The main noticeable difference was that instead of three teaching across both types of programmes as at Stage 2a, now seven of the group of fifteen taught across both pre and post-registration work and had developed a 'specialist expertise'. Consequently, they were involved in a wider range of the programmes offered. None delivered programmes at degree level but four participants stated that this had been discussed as a possibility. One nurse teacher stated that they had purposely met with an existing lecturer from University A in order to *'map out some potential development opportunities' (Interviewee 2b.11).* This included teaching at level 3 (degree level) and supervising research students.

8.4.3. Current Role Attributes

Hardy and Conway (1987) suggest that perceptions of current role are important in understanding clarity. It was therefore useful at the merger point into higher education to evaluate the nurse teacher's perceptions and responses to any change in role. In reporting Stage 2a findings (Section 8.2.3), current attributes were organised into classroom role, student issues, clinical role, managerial/administration duties and personal attributes. This framework continues here to present emerging findings with an overview presented in Table 8.14.

Table 8.14. Current Role Attributes AT the merger (Stage 2b)

Key group attributes identified in literature	Specific attributes identified in the study	Multiple 'key phrases' identified (n =)
1. CLASSROOM ROLE	Development of students	15
	Teaching skills	8
	Linking theory to practice (Classroom)	7
2. STUDENT ROLE	Communicating with students	15
	Development of students	15
3. CLINICAL ROLE	Nursing expertise	12
	Communicating with clinical staff	9
	Linking theory to practice (Clinical)	9
	Clinical credibility	8
4. MANAGERIAL/ ADMINISTRATION ROLE	Administration/managerial – marking, correspondence, meetings and course organisation	7
5. PERSONAL ROLE ATTRIBUTES	Academic experience	15
	Communicating with colleagues	15
	Communicating with senior managers	15
	Adaptation skills	12
	Positive personality	10
	Autonomy	5
	Positive role model	5
	Motivation	4
	Questioning skills	3
	Networking	1

8.4.3.1. Classroom Role

All the nurse teachers felt that the time spent in the classroom developing students remained satisfactory and continued to be essential to their role. The attributes commonly identified were development of students (15/15), teaching skills (8/15) and linking of theory to practice in the classroom (7/15) (Table 8.14). Four expressed concerns that larger student group sizes in higher education would affect the development of nursing students. These findings support Carlisle et al (1996) who found that larger group sizes in higher education directly related to difficulties in maintaining relationships with students:

'I think there's going to be huge group sizes in the classroom and that will not help develop specialist or practical skills which I believe nurses need' (Interviewee 2b.2)

'I have been told that I have to teach communication to group sizes of up to 60 which I consider to be unreasonable – actually no it's a joke as communication exercises really only work in smaller groups where dynamics can be explored properly' (Interviewee 2b.9)

8.4.3.2. Student Issues

Data emerging at this stage indicated that as Stage 2a, both communicating with students (1515) and their development (15/15) was important to the nurse teachers (Table 8.14). Three isolated comments were also made about the need for stability for the students at the time of the merger:

'Well, its bad for us, but you have to just carry on for the students – some of them are feeling the disruptions – I try not to show it but I know of other colleagues who have been less discreet' (Interviewee 2b.5)

'I think we owe it to the students to just deliver everything as it has always been ... I just come in every day ... do my bit ... keep a positive mind during all of this ...at the end of the day we have no real power over this transfer so that's the way to be' (Interviewee 2b.7)

'So far I think its all gone very well actually for the students – they are not really that stressed – its us – its our contracts and work that will be affected by all this' (Interviewee 2b.14)

8.4.3.3. Clinical Role

Elements for discussion in this section will include nursing expertise (12/15), communicating with clinical staff (9/15), linking of theory to practice as part of the clinical role (9/15) and clinical credibility (8/15). Twelve nurse teachers felt that nursing experience was still essential in order to perform the role effectively. Comments included:

'I feel very strongly that nurses should teach nurses and that they should be credible both in terms of nursing experience and qualifications' (Interviewee 2b.10)

'I think I may have to rely on my clinical experience more than ever now as I can't help but feel that life in the university may bring a different set of values with it ... as yet I am very unsure what they value which I guess is worrying isn't it? (Interviewee 2b.4)

Nine participants felt that communicating with clinical staff and the linking theory of nursing to practice would be even more important in their new 'lecturer' role. Although all 15 participants were still 'named links' to a ward or unit, comments at this time related to the potential loss of this role as a result of the merger into higher education. This was similar to the findings of Day et al (1998) (Chapter 3; Section 3.4.4), who noted that loss of the clinical link role had had a detrimental effect on the ability of nurse teacher/ lecturers to maintain clinical credibility. Suggestions of

'protecting' the role included the continuation of visiting students on placements (five comments) and being given time and opportunities to develop clinical skills (four comments). Others noted:

'Even though we weren't really performing an active link role particularly, I still feel it's very useful to have some sort of contact ... we should definitely protect it or develop it especially whilst we find our feet in the university' (Interviewee 2b.8)

'We haven't really felt the impact yet because its business as usual but in relation to the theory-practice link role, we really owe it to the clinical areas to offer something.... perhaps it's time to carve out a new role – I don't know what though ...but we could surely put our heads together in order to ensure we have good theory-practice links otherwise how can we be credible in the future' (Interviewee 2b. 9)

8.4.3.4. Managerial and administration role

Clifford (1995a) found that 67% of a sample of 126 nurse teachers noted that too much time was spent on administration and management attributes of the role. It was therefore useful to examine how the merger into higher education affected nurse teachers managerial and administration role. In this study, seven nurse teachers' felt that administration and managerial duties, such as meetings, typing, timetable planning and booking rooms still dominated the role and five commented that this had increased as nurse teachers became more autonomous in their work. Three of the five felt that there was much confusion at the merger point as to who was responsible for managerial and administration duties so *'little is getting done' (Interviewee 2b.11).* One suggested,

'We all feel we are waiting for this merger to happen – there's a kind of wait and see policy – it's unspoken but its definitely going on so administration is low on the priority list right now I feel' (Interviewee 2b.3)

Three nurse teachers also mentioned that they were *'losing experienced educational and administrational staff' (Interviewees 2b.7; 2b.14 and 2b.15)*. This was due to the policy that each college had to streamline their workforce following the identification of a staff surplus (Cox 1993). This 'loss' of key staff was a concern to the nurse teachers and more specifically how work would be devolved when individuals left the organisation. It is worthy of note that losing key members of staff had subsequently created a degree of dissatisfaction in these three respondents. No other study could be found which explored the impact of losing key personnel as a result of the merger events into higher education and thus it was not possible to determine if such a pattern may have been anticipated.

8.4.3.5. Personal Attributes

At Stage 2b, all participants felt that academic expertise was essential (15/15). Fourteen participants had completed a first degree (an increase of 1 since Stage 2a), three had obtained a Masters degree (no change from Stage 2a) whilst three were now registered on a Masters programme (an increase of 1 since Stage 2a). No other higher degrees were held. Interestingly, at this stage several participants identified that motivation for further studying had been accelerated as a direct result of the merger into higher education.

This is supported by a study in Finland that found that as a result of the merger into higher education nurse teachers were *'under pressure to develop oneself'* (Harri 1997). This perception is illustrated in the following extracts:

'I feel that my academic qualifications will be even more important in the future – its not that I'm selling out but rather representing what I feel will be expected of us' (Interviewee 2b.2)

'I feel my Masters degree will give me an edge in the university'

Interviewer: Why do you think this?

'Because this is what's valued in the university I think.. and what they look for in their staff.. and if it means I survive all this then all that studying will be put to good use!' (Interviewee 2b.12)

'I finished my degree in the university we are going into and feel therefore it has been very useful because it gave me lots of confidence about my academic abilities and helped me make some new contacts ready for when we transfer' (Interviewee 2b.14)

At the merger point all nurse teachers also felt that 'good' communication skills with colleagues and senior managers were needed to perform the role (15/15) (Table 8.14). As indicated at Stage 2a, ten nurse teachers felt at Stage 2b that they needed to have a strong personality, five felt it was important to be a positive role model and four felt the need to be motivated. Conversely, only three nurse teachers at Stage 2b felt questioning skills and one felt networking skills were required. The following extracts would seem to support this preliminary finding:-

'I feel more than ever that I will need to adapt to the forthcoming events – I'm unsure what that will entail at this moment in time but I feel I have the sort of personality that can adapt well to change' (Interviewee 2b.1)

'I have a very determined personality which I will need to use more than ever now as this merger is quite a disturbing time for us – I mean that a few months ago we were very naïve about the entire process but we are learning as we go along – I'm not sure that's the way to prepare for such an event as its reactionary – however what strikes me is we will need to be resilient and draw on personal attributes' (Interviewee 2b.5)

Furthermore, 12 lecturers highlighted that adaptation skills were required to perform their current role (an increase of 9 from Stage 2a;Table 8.4), and five felt that being autonomous in the role was required (3 increase from Stage 2a; Table 8.4). Previous studies of nurse teachers explaining this finding were limited but Handy (1993) suggests that individuals draw on their own personal traits in time of stress or role conflict.

8.4.3.6. Most important and worst aspects of the current role

A further key area explored was perceptions of the 'most important' and 'worst' aspects of current role, each participant having only one choice (Table 8.15). Nurse teachers felt that most important aspects were the ability to adapt to the new working environment (5/15), course delivery (3/15), student development and support (3/15), to use effectively communication pathways (2/15) and to draw upon their nursing and teaching experience (2/15). It is interesting to note some slight changes from Stage 2a most notably that adaptation had not featured at Stage 2a (Table 8.5).

Table 8.15. Most important versus worst aspects of role at Stage 2b
(One choice per participant)

Most Important	Responses	Worst Aspects	Responses
Adaptation skills	5	Diversity of role	8
Course delivery	3	Lack of time	4
Student development/support	3	Meetings	2
Communication strategies	2	Clinical update	1
Nursing /Teaching Experience	2		
(Total = 15)		**(Total = 15)**	

The 'worst' aspects of the role at Stage 2b included diversity (8/15), lack of time to undertake all expected aspects (4/15) and meetings to be attended (2/15). These findings were similar to those found at Stage 2a. One extract exemplifies feelings at this time:

'I feel we have to keep fairly sane at this time – many tutors are understandably very stressed about the merger so probably the most important attribute is to keep calm and adapt quickly by devising positive strategies to survive!' (Interviewee 2b.7).

8.4.4. Future Role Attributes

The nurse teachers expected that the future nurse lecturer role would be different after the merger had taken place (Table 8.16). More specifically fourteen participants expressed the thought that higher academic qualifications would be valued, ten felt that the role would be more 'autonomous' (an increase of 13 from Stage 2a; Table 8.4) and nine felt that research/publishing activities would be essential (an increase of three from Stage 2a; Table 8.4). This was also noted by

Luker et al (1993) who found that 46% of their sample of nurse teachers identified that obtaining a higher academic degree would be required as the role evolved in higher education.

Table 8.16. Expected Future Role Attributes in Higher Education at Stage 2b

Future Attributes	Responses (n = 15)
Academic Qualifications	14
Autonomy	10
Research & Publishing	9
Networking Skills	7
Adaptation Skills	5
Nursing Expertise	5
Theory/Practice skills	4
Teaching skills	3
Unsure also stated in responses	9

Future role attributes identified by seven nurse teachers were that the merger could provide additional networking opportunities, an increase of 4 since the Stage 2a interviews. To a degree this reflects the finding of Luker et al (1993) who found that 77 (16.2%) of their survey respondents felt the merger into higher education would bring *'increased networking opportunities'*. The following comment exemplifies such feelings in this study:

'I expect there will be more networking with other professional groups – the university is such a wide mix – more than an isolated college of nursing' (Interviewee2b. 6)

In contrast, nine participants added that, although they understood this line of questioning, they were really still unsure about the expected future role attributes as they had never experienced higher education before apart from being students themselves. The following extracts support this:

'Even though I hope I'm going to be academically challenged more in the university I have this feeling its going to be the same old job – but a new job title and employers – right now I'm really unsure about answering this question as I have no idea how it will turn out' (Interviewee 2b.4)

'I actually have no idea what it will be like – we have had some preliminary information but actually no-one has informed us of the expected role – my worry is we will be expected to make it up as we go along' (Interviewee 2b.3)

8.4.5. Cultural and Organisational Understanding

Sackmann (1991) suggests in order to understand the cultural knowledge the research must determine what the culture means to key individuals. Thus, nurse teachers were asked to identify three attributes fundamental to the working of University A, in order to ascertain their understanding of current cultural and organisational attributes at the time of the merger. Responses were divided into four categories of formal and informal rules, internal and external communication pathways, administration and bureaucracy, and expected delivery and developments as illustrated in Table 8.17.

Table 8.17.
Key cultural and organisational attributes of the University A at Stage 2b

Participant	Rules	Communication	Work Organisation	Curricular Developments
1.	Unclear rules	Autonomous working patterns with flexible, flattened structure		Emphasis on level 3 work or higher levels
2.	Unclear rules – its all unknown to me	Unclear and unsure who everyone is.	Unclear organisation of work allocation Unclear value of nursing within wider culture of higher education	
3.	Unclear rules	Unsure who is who and what everyone does		Different curricular delivery such as modular and more wider choice but larger group size
4.	Unclear of informal rules although formal starting to receive information	More networking externally and with other professions	Much confusion over who's who in administration delivery	More research development and delivery
5.	Unclear work distribution	Clear leaders but more flattened structure (less hierarchical)		More emphasis on academic higher awards and levels
6.		Possibly less cohesive as more autonomous	Administration structure unclear to date	
7.	Unclear about classroom and clinical rules related to role	Flattened structure		Academic development and research/ publishing pressures greater
8.	Structure of rules is currently unclear - learning as we go along	More working alone (self motivated) and wider skills and subjects taught		Larger student groups

9.		Less emphasis on development of clinical skills and quality due to large numbers of students	Some confusion over distribution of secretarial and administration staff	More pressures to deliver as more competitive market
10.	Flexible rules and working environments	Less team orientation and more autonomy		Academic development greater for students and staff
11.	Rules not clearly defined to date	No team work as we know it but they do have clear schools within a faculty of health		Appears to have clear academic goals in modular delivery
12.	Unclear rules but ?less emphasis on the clinical role of nurse teachers	More autonomous structures		More emphasis on academic development
13.	More flexible rules	Less 'hierarchical' in University A.		New and exciting delivery of nursing course and improved student facilities
14.	Unclear - less emphasis on development of clinical skills	Currently unsure who is who and what everyone is supposed to be doing (Role confusion)		Larger student groups
15.	More flexible rules	Flexible, autonomous culture		New curriculum delivery Academic development greater

Nine participants suggested that, whilst they understood the need for the merger, their understanding of both the culture and organisation of the university was at that time limited. Culture was thus *'unknown'* to them (*Interviewees 2b.1; 2b.2; 2b.3; 2b.4; 2b.7; 2b.8; 2b.11; 2b.12 and 2b.14*).

A theme of 'formal and informal rules' re-emerged from Stage 2a, in that ten participants stated that the rules were unknown to them and only two stated that they believed that the *'university rules were more flexible'* (*Interviewees 2b.10 and 2b.13*). This was in contrast with data collected at Stage 2a, when ten nurse teachers felt that formal and informal rules of College A. were much needed and were clearly understood.

Communication pathways within the structures of University A (Table 8.17) were also discussed. This was interesting because, whilst participants were unsure about the 'rules' of University A, only three said they were unsure about whom to communicate with (*Interviewees 2b.2; 2b.3 and 2b.14*). Conversely, eleven participants suggested a range of models including:

'autonomous working patterns with a flexible, flattened structure' (Interviewee 2b.1)

'no team work as we know it in the college but they do have clear schools within a faculty of health' (Interviewee 2b.11)

'flexible, autonomous culture' (Interviewee 2b.15)

The words 'autonomous' and 'flexibility' featured in many interviews on several occasions. Hofstede (1994) suggests that in 'merger events' it is common for individuals who in reality do not understand the new culture use words that they think might be associated with that culture, often through word of mouth sources.

Organisation of work was raised by four participants *(Interviewees 2b.2; 2b.4; 2b.6 and 2b.9)* (Table 8.17). All agreed that there was some confusion about work allocation, specifically relating to administration staff. Curricular development and delivery was also interesting to record at Stage 2b. Nine participants felt that working in higher education would result in modular-type curricular delivery at higher, academic levels (degree) and greater research development *(Interviewees 2b.1; 3b.3; 2b.4; 2b.5; 2b.7; 2b.12 and 2b.15)*. Concerns raised related to larger groups sizes *(Interviewee 2b.3; 2b.8; 2b.14)* and more pressures to deliver in a competitive market *(Interviewee 2b.9)*. However, benefits of higher education included clear curriculum plans *(Interviewees 2b.11 and 2b.13)*, improved academic development for students and staff *(Interviewee 2b.10)*, and improved student facilities *(Interviewee 2b.13)*. Interview extracts demonstrate these issues:-

'Although we had a formal welcome day and I do feel that I am starting to get to know a little about the university, I still feel very unclear about the structure of the organisation – I don't know what the informal rules are and I don't expect to know but I also don't feel comfortable with the formal rules either at this point in time – for example who I contact for a specific problem or need' (Interviewee 2b.4)

'It's a difficult time for us to grasp a new culture – we have experienced so much turbulence that survival is the name of the game now for a lot of nurse teachers I'm sure – previously our understanding of the college was very good but now we appear to learn the rules as we go along– what worries me is we seem to learn it from each other and that can't be an ideal way to learn of this new culture' (Interviewee 2b.8)

'I think its going to be difficult for many tutors in this new culture as I believe it's a more flexible, autonomous culture – I feel we have not been used to this in the colleges of nursing or indeed nursing itself because fundamentally we come from a culture where we follow rules – don't rock the boat – so this brave new world may be a big shock for us' (Interviewee 2b.15)

'If I put my personal feelings to one side and tell you that what I hope for is new and exciting delivery of nursing courses and I hope going into the university will bring that. I therefore hope the new managers will facilitate a model that fosters such an environment' (Interviewee 2b.13)

'I hope in the possible flexible working environment that we are about to experience that we tutors become more autonomous – I think that this is a great opportunity for nurse education and the academic development of nurse teachers and students should ultimately bear fruit, I hope' (Interviewee 2b.10)

8.4.6. Personal information about higher education

Personal information about higher education was explored to ascertain how individual nurse teachers were carving out their role as a result of the merger into University A (Table 8.18).

Table 8.18. Personal preparation about higher education at Stage 2b

Preparation used	Responses
Communication With college staff	15
Direct communication with union representatives	11
Reading published literature (e .g . journals)	9
Utilisation of own experience (research/academic courses)	4
Communication With university staff	1

They stated that they wanted to learn about the university organisation and structure so used their own communication channels to facilitate this process. All fifteen cited that their main source of personal preparatory information came from one another or *'from those colleagues I most trust or respect' (Interviewees 2b.6 & 2b.9)*. Eleven respondents also included references to the 'union representation' which was considered to be *'excellent'*. Nine claimed that they had read some published literature about merger events across the UK, whilst four intended to use their own experience of being previous students in a university structure. Barton (1998) also found that the nurse teacher sample in his study was not prepared for the merger event. Hofstede (1991) notes this is common and as a result anxiety can be heightened. Interview extracts highlight these findings:-

'Like a lot of tutors, I tend to communicate amongst those whom I trust but really we should be supporting each other more as a collective group ....and discussing how important it is to carve out a role with respect to what we believe - I do feel we are allowing this to happen and actually it has a huge impact on our role and the quality of education we deliver' (Interviewee 2b. 9)

'Personally, I feel very strongly that it's up to us to determine our own role – previously we have had a hierarchical model of management... what we do know is that the university model is more flattened in structure and more self – autonomous so it must be up to us as individual tutors to find strategies which really show off our skills' (Interviewee 2b.5)

'We really prepare ourselves better through communicating more effectively and be prepared to speak up more about what we do that's unique to us and how important our clinical links are, but we don't tend to do this as a group. I do as an individual but I keep feeling I'm going to be labelled soon for doing this' (Interviewee 2b.2)

Only one nurse teacher stated she had contacted a lecturer who already worked for University A in the existing nursing department. Her reason given is illustrated:

'I felt I have got to know the person well enough over the years to pick up the phone and ask them the 'low down' so to speak – it was very useful as I discovered that they are as anxious as we are about this merger'...

Interviewer: Do you feel that it was useful to do this in terms of your personal preparation?

'Yes ... I think we should have more opportunities to get to know one another – I get the impression that we (tutors) will be lucky to get jobs – somehow its perceived we aren't well developed – but when I spoke to X she told me that wasn't the case... If we had more opportunities to contact one another or have a buddy system I'm sure that this would feel more like a merging process' (Interviewee 2b.11)

8.4.7. Organisational information about higher education

In response to questions about organisational preparation for the merger event, all fifteen of the nurse teachers had attended a '*welcome study day*' at University A (Table 8.19).

Table 8.19. Organisational preparation about higher education at Stage 2b

Organisation Preparation	Responses
Attended a welcome study day Organised by the university	15
Formal meetings (College of nursing/union)	15
Informal meetings (Manager/Teams)	10
Correspondence (from College)	15
Additional correspondence (from university)	4

Although this induction was felt to be informative, eight interviewees added that the 'merger' felt like a *'take-over'* and a further four felt *'unwelcome'*. Thirteen stated that job contracts were an important issue but were still being negotiated at the time of the merger and this was felt to be *'unhelpful in reassuring lecturers about their specific needs' (Interviewee 2b.15)*. In addition to the welcome day and information provided, only four stated that they had had any form of official correspondence from University A.

Conversely, all of the nurse teachers had attended numerous events organised by the college of nursing and or formal union meetings (Table 8.19). Ten stated they had had additional feedback from their direct line manager in their working teams and all had received some form of written communication from College A. Extracts are illustrated:-

'We did have a formal welcome induction programme offered which was felt somewhat like a take-over – I think we are prepared to accept the university rules and ways of doing things but no-one asked us how we did things and after all we have been delivering nursing courses for years' (Interviewee 2b.3)

'The union representation has been excellent at guiding us through all this but we have had little organisational preparation about our new roles in the university – the impact of this would seem a little worrying actually' (Interviewee 2b.12)

'I feel there has been little recognition of how highly skilled we are as a group' (Interviewee 2b.8)

'Here we are all very anxious and desperate to learn about this brave new world we are entering and we do want to enter it – but sadly to date the lack of information has only added to peoples fears' (Interviewee 2b.6)

8.4.8. Benefits of role in higher education

The purpose of ascertaining three perceived benefits of the nurse teacher role in higher education was to build up a picture of feelings about the merger event as it occurred and identify how these might impact on perceived role. Positive responses were noted as presented in Table 8.20. Fourteen nurse teachers considered the merger to be 'essential' in facilitating professional development of nursing and thirteen felt that working for a university as a lecturer might bring with it increased job status. Such responses highlight this:

'Although problematic now as we merge I hope in the long term it will push the boundaries of nursing more and develop not only me but all nurses as a result' (Interviewee 2b.14)

'I have high expectations for the future – what we have to do is carve it all out now – ensure our teaching role develops as we want it to – speak up about what's important to us but ultimately this merger should develop us all as a professional group' (Interviewee 2b.11)

'In part the title 'Nurse Tutor' always sounded very important to me when I was a student so saying I'm a lecturer or Senior Lecturer for a university sounds even better right now!' (Interviewee 2b.7)

Table 8.20. Perceived benefits of working in higher education at Stage 2b

	Responses
Develop professional base of nursing	14
Increased 'job' status	13
Research / publication development	10
Increase networking opportunities	9
Self personal development	9
Further academic development	6
Flattened organisational structure	2
Less theory / practice gap	2

Ten responses also indicated that, as a result of the merger nurse teachers would need to publish or be involved with research activities more than they had previously. It was felt that this would enhance aspects such as increased networking in the wider world other than nursing (9/15), a sense of increased personal (9/15) and academic (6/15) development.

'I really hope that this merger will help me develop in my research activities – I have always been interested in research but I hope the university philosophy will support such activities more – I think that's one way we could contribute to the evidence base of nursing whilst also giving us some sort of clinical foothold and remain credible – In doing such activities I would also hope to be encouraged and supported in publishing more and thus developing my academic profile as a result' (Interviewee 2b.6)

An awareness of the 'flattened structures' of higher education (2/15) and potentially less theory / practice gap (2/15) was also identified as a potential advantage (Table 10.19). Responses included:

'I'm looking forward to the flattened structure – I have always felt the college to be somewhat repressive in management so a definite advantage for me is the new structure where I can develop without someone looking over my shoulder' (Interviewee 2b.1)

'Well, an advantage would be what I mentioned earlier and that's the new working structure – more autonomous – that's one thing I picked up from the welcome day – more flexibility – yes please!' (Interviewee 2b.10)

'I have a feeling I might be on my own with this one but I think that this perceived theory-practice gap may get less – certainly if you examine the market forces argument, nurse education as we know it will be more driven by the Trusts – especially in the competitive market and also if you look at other professions they have to be so accountable now – I think that's what will happen – we will become more accountable and driven to deliver what the Trusts want, not what we want as some elite little band – that can only be good and possibly reduce the theory – practice gap given time' (Interviewee 2b.13)

8.4.9. Perceived Problems of role in higher education

Perceived problematic issues related to role were explored to help identify negative feelings about the merger. At this stage nurse teachers re-iterated concerns for the potential loss of clinical skills (14/15) and the consequences of that such as a perceived theory / practice gap (9/15) (Table 8.21).

Table 8.21. Perceived Problems of role in higher education at Stage 2b

	Responses
Loss of clinical/nursing skills	14
Increased anxiety due to pressures	14
Components of Anxiety x 14:	
Increased role demands/stress	6
A feeling of marginalisation	5
Increased academic pressure and research/publish demands	3
Change of Teaching Style	10
Wider theory / practice gap	9
Change of organisational structure	7
Lack of managerial support	4

Using role theory literature of Biddle and Thomas (1966) (Chapter 3), 'role conflict' was explored in the transcripts of this study and was found to largely fall into two categories. Eight nurse teachers expressed concerns that whilst they were expected to develop academically they were at the same time unsure of their job contracts and expected teaching/clinical role. In this way they were torn between their previous expected 'nurse tutor' role working within a college of nursing

within the NHS whilst having to accept the new 'nurse lecturer' role and culture within higher education. One nurse teacher stated '*I feel like I'm selling out on nursing and other nurses' (Interviewee 2b.5).* Six also expressed a concern that time to develop clinical expertise was viewed as a low priority in HEIs. One nurse teacher illustrated this:

'it's pulling me away from the grass roots – there will be no time to develop and yet I'll still have to teach the practical skills – this concerns me as teaching a practice like nursing depends on doing the practice and that to me means me doing it not reading about it!' (Interviewee 2b.13)

It was also interesting to record that the group felt that as a result of the merger a change of teaching style (10/15) and organisational structure (7/15) would add to possible problems. In fourteen responses there were references made to increased anxiety and stress as a result of perceived increased pressures in higher education. These references related specifically to increased pressures of role demands (6/15), a feeling of marginalisation (5/15), increased academic development pressures and research or publication activities (3/15). Interestingly four of these nurse teachers also envisaged that, whilst there would be more pressures, managerial support would be less due to flattened structures. Barton (1998) found in a study of nurse teachers a similar pattern of role conflict and feeling of marginalisation as a result of the merger into higher education. Extracts from interviewees are illustrated:-

'Unless we have some sort of definite strategy for bridging theory / practice of nursing we tutors are going to really miss out – we will be less clinically skilled' (Interviewee 2b.9)

'I think expectations are high about nurse education being university driven which inevitably puts pressure on us to perform – I envisage larger groups, less managerial support and increased personal stress as a result' (Interviewee 2b.2)

'Everyone is terribly anxious at the moment – about who's staying and who's going and who will do what and where we will be situated – we keep hearing there's going to be more pressures on us but we don't know what kind - we feel a definite feeling of bewilderment and some of it seems quite strategic to keep us down as a group'

Interviewer: 'Can you expand on the type of pressures that you feel will be increased'?

'Yeah – I think its got to be academic – probably as a school or whatever in terms of new modular courses to be written ...(we heard about these on the welcome day)...and personal pressures such as higher degree development – I do feel anxious and keep looking for other jobs but where do I go!?' (Interviewee 2b.7)

8.5. Summary of Stage 2b findings

Emerging data at Stage 2b, highlighted that the nurse teachers had all continued their multi-faceted role as identified at Stage 2a, and that the role had not significantly changed at this stage.

With respect to the key cultural and organisational issues of rules, communication networks, work organisation and curricular developments nurse teachers were generally unclear about University A and that they had mixed feelings about the merger into higher education as a result. Several comments were made, however, that the 'merger event' would be essential for the development of nurses and profession of nursing. Emerging data also indicated that nurse teachers were beginning to 'feel' a change in the organisational culture. Some of this was precipitated by additional information received from College A and University A, although this was felt to be mostly conversational and of limited value.

There was some confusion over title, some participants identifying with 'Nurse Tutor', whilst others were unsure and only a handful felt that it was 'Senior Lecturer'. Some of this lack of title clarity appeared to relate to not having their 'job contracts' and may have contributed to increased uncertainty and stress levels. Findings indicated that nurse teachers felt the need to 'prove' themselves and a feeling of powerlessness. Furthermore, on a personal level nurse teachers appeared to feel a loss of identification and a degree of marginalisation as a group. Such

findings examined in isolation may be overlooked but considered collectively were a concern.

What was interesting at Stage 2b was that nurse teachers expected the culture of University A to be 'different' and were very anxious about this. Some appeared even resistant to the forthcoming change. Examples of 'differences' in organisational culture were noted in the responses relating to future role attributes. Similar to Stage 2a, these were untested assumptions, but were thought to include the need for higher academic qualifications, being more 'autonomous' and undertaking more research/publishing activities. In order to prepare for these activities, personal attributes such as adaptation, improved communication strategies and a positive attitude were felt to be required.

Future role attributes related to perceived benefits and problems. On one hand nurse teachers felt that the 'nurse lecturer' role would bring more development opportunities, better job 'status' and wider networking skills. On the other hand, they expressed concerns that this would ultimately increase work pressures and may limit their development of clinical expertise. Thus, in this model, personal nursing credibility might be limited and role conflict could be high.

Overall at Stage 2b, data indicated that the nurse teachers had not totally felt the impact of the 'merger event'. This may in part have been due to the lack of cultural awareness about higher education and their expected role. This raises the question whether such findings had an impact on their role perception and subsequent performance following the merger into higher education. The next section reports on the perceptions of this group a year after the merger into University A at Stage 2c of the study.

8.6. Nurse teachers AFTER the merger (Stage 2c)

The findings of Stages 2a and 2b demonstrated that whilst the nurse teachers felt the merger was essential for the development of nurses and nursing their cultural knowledge of higher education systems was limited and as a consequence adaptation strategies were needed. This section summarises the findings of fifteen nurse teachers one year after the merger from College A in the NHS, into University A. The reported framework is as previous sections and interviewees are identified as *2c.1 to 15*.

8.6.1. Current Job Title

The purpose of recording title after the merger was to record change with respect to the impact on nurse teacher role. One year after the merger all the nurse teachers highlighted that in contrast to their view of the merger (Stage 2b) there was no confusion about their title within University A. The university contracts stipulated that they were either Senior Lecturer (14/15) or Principal Lecturer (1/15) as demonstrated in Table 8.22. However, ten stated that, when talking to clinical staff on the telephone, they referred to themselves as both nurse lecturers and nurse tutors according to whom they spoke with. The other five stated that they always used their first name before discussing their titles as they were known to most of their contacts.

This is illustrated:

'I'm now a Senior Lecturer – the majority of us are – and I think that's right but when I'm on the telephone to ward staff it's still a bit weird to say it so I tend to say nurse tutor and sometimes I say both! Mostly I get away with just using my name because they usually know me and actually I don't have a problem using the titles interchangeably now because its useful to relate to different groups at different times' (Interviewee 2c.1)

' I signed my contract as Senior Lecturer and that's what I use internally here in the university or externally with other universities or at conferences but externally to my clinical areas I still use nurse tutor or my name as they I don't feel they really relate to us as lecturers yet. Perhaps that says more about me letting go though not the clinical areas acceptance of us' (Interviewee 2c.9)

Table 8.22. Job title in University A at Stage 2c

Job Title	Responses
Nurse Teacher	0
Nurse Tutor	0
Nurse Lecturer	0
Senior Lecturer	14
Principal Lecturer	1
Unsure	0

8.6.2. Career plan/biographical Profile of nurse teachers

Eleven nurse teachers were teaching and organising diploma level 1 and 2 work across the pre-registration nursing courses offered. In University A, a pre-registration degree was offered but was still organised by staff who were established university staff before the merger although there were plans for this to change. One of the eleven pre-registration teachers had some involvement at degree level in that she had supervised two students for their research dissertation. Seven of the eleven had also taught up to level 3 (degree) across the nursing programmes offered by the

faculty. The remaining four nurse teachers delivered post-registration courses up to level 3 (degree) and two of the four had started supervising students for their research dissertation at level 3 (degree). One participant of this four held a senior post of Principal Lecturer and so was also responsible for organising a course team.

8.6.3. Current Role Attributes

Perceptions of current role were required to evaluate any change in role attributes as a result of the merger into higher education. Current role attributes are outlined in Table 8.23 as discussed further below.

Table 8.23. Current Role Attributes after the merger (Stage 2c)

Key group attributes identified in literature	Specific attributes identified in the study	Multiple 'key phrases' identified (n =)
1. CLASSROOM ROLE	Development of students	15
	Linking theory to practice (Classroom)	14
	Teaching skills	9
2. STUDENT ROLE	Communicating with students	10
	Development of students	10
3. CLINICAL ROLE	Nursing Expertise	11
	Communicating with clinical staff	6
	Clinical credibility	5
	Linking theory to practice (Clinical)	4
	Clinical credibility	5
4. MANAGERIAL/ ADMINISTRATION ROLE	Administration /managerial – marking correspondence meetings course organisation	15

5. PERSONAL ROLE ATTRIBUTES	Academic Experience	15
	Communicating with colleagues	10
	Networking	9
	Autonomy	9
	Adaptation skills	12
	Positive Role Model	8
	Creativity	8
	Motivation	6
	Communicating with senior managers	6
	Questioning skills	3
	Hard working	5

8.6.3.1. Classroom role

'Common' attributes identified include development of students (15/15), linking of theory to practice in the classroom (14/15) and having a variety of teaching skills (9/15) (Table 8.23). When further exploring the meaning of 'relating theory to practice' ten nurse teachers suggested that they felt that they were in a prime position to teach the theory of nursing, which underpinned care. Four felt that when they were teaching 'theoretical principles of nursing', they were able to use their clinical experience in the classroom to underpin information.

As in Stages 2a and 2b, all the nurse teachers felt time in the classroom *'was still about right'* and was felt to be crucial to the teacher role. However, a change was noted in relation to the class sizes, 10 participants expressing concern about the *'larger class numbers of students'* and a *'lack of continuity in the students development'* as a result of the modular system of programmes within the curriculum of University A.

One nurse teacher also felt:

'I thought the academic standards like in the classroom role were going to be much higher and I was worried about teaching modules but the reality was not much of a shift. The entire process to me has been like getting to The Wizard of Oz only to find it's man behind a curtain!' (Interviewee 2c.2)

8.6.3.2. Student Issues

The analysis highlighted that the development and communication with students was felt to be important aspect of the role (10/15). Moreover, four nurse teachers made comments that they felt in the university students were given '*less pastoral support*'. Group sizes were also problematic as ten of the nurse teachers claimed they had taught group sizes up to 70 and one stated 120. They made comments such as '*it was difficult to maintain relationships with students' (Interviewee 2c.4).* References were also made about the '*the higher wastage rates', 'not knowing who the students are any more'* and *'frustration of monitoring student attendance and development'.* No study could be found to support this finding that modular teaching and dissatisfaction in role may be connected.

8.6.3.3. Clinical issues

Nurse teachers referred to nursing expertise (11/15), clinical credibility (5/15) and the linking of theory to practice as part of their clinical role (4/15) (Table 8.23). As these attributes had also emerged from data at Stage 2a and 2b interviews, each will be discussed.

Eleven of the nurse teachers felt it was essential to have nursing expertise as a 'nurse lecturer' if they were to perform their role effectively (15 at Stage 2a and 12 at Stage 2b). Many commented that experience had been gained in their '*previous career*', but it was this experience that was valuable in their current role. One senior lecturer commented:

'Although for me my nursing experience feels a long way back now at least I can still draw upon it. I know if I actually worked on the ward now it would take me a few days to learn the current practice but I think I still could...I feel therefore it's essential to have that experience to draw upon in my teaching ... and also to have confidence about what I did when I was in practice' (Interviewee 2c.8)

Interestingly, whilst participants felt that nursing practice was important in their role, only four claimed to be given actual 'contract time' for this as part of their current role. This contrasted with twelve participants at Stage 2a and nine participants at Stage 2b showing a decreased pattern overall. This finding is supported by Day et al (1998) who found that, after the merger into HEIs, 'nurse lecturers' did not get time and opportunities in the clinical area to keep skills up to date. The remaining eleven stated that this was the *'first thing to go'* after the merger into higher education, again reflecting earlier research by McElroy (1997).

Five nurse teachers (three from post-registration teaching teams and two from pre-registration teaching teams) stated that *'clinical credibility'* was an attribute they still felt they possessed in their role (*Interviewees 2c.3; 2c.5; 3c.6; 2c.11 and 2c.14*). However, three other nurse teachers from the pre-registration teaching teams expressed regret that they were not given enough opportunity to develop their

clinical skills within the university. Such findings are also supported by the Day et al (1998) project that identified problems of linking theory to practice as a consequence of not keeping clinical skills up to date. Some of their concerns are noted in the following extracts:-

'I'm sure some of this loss of the clinical role has to lie on our doorsteps because it wasn't protected enough – in the colleges the role was just accepted but in this university we didn't fight for it as crucial – maybe some lecturers don't think it is crucial but I do and feel in this respect we have created a climate of academics do the teaching and assignment work whilst practice nurses do the mentoring and skill development' (Interviewee 2c.4)

'Well, I think we are really losing out if we don't link theory and practice because after all the clinical staff are our purchasers and we should really demonstrate to them we not only give quality theoretical courses but we also believe in quality practical courses as well – at the end of the day that's what our credibility rests on' (Interviewee 2c.7)

Respondents were asked to ascertain how this role could be developed in the university. Individual suggestions included being *'more strategic in the role'*, *' developing partnerships with clinical staff and clinical trusts'*, and *'developing partnerships with the other universities'*. More frequent suggestions were mapped together as outlined:

- Creative partnerships in the university and clinical staff (6)
- New model of strategic activities in clinical liaison role (5)
- Utilisation of more clinical staff in course delivery (4)
- Creation of new university/hospital posts (4)
- More voice from clinical areas re: concerns about theory-practice (3)

8.6.3.4. Managerial and administration role

All of the fifteen nurse teachers stated that the administration and managerial role featured heavily within role attributes (Table 8.23). This was not a new finding in the study reported here but the expectations of role may have been changed by the merger event. For example, emerging data indicated that nurse teachers now spent more time on administration, such as photocopying, typing on computers and answering emails. All stated that the time undertaking such duties was excessive and largely due to the perceived loss of administration personnel. However, two added that computer resources were better in the university so they actually felt it was 'quicker' to do their own work. Comments included:

'I do much more of my own typing since the merger – the typists we have are so thin on the ground now I feel I have to do it' (Interviewee 2c. 6)

' I do give them essentials but they have so much work and are expected to not only type but be receptionists and do a lot more that I feel I can't ask them' (Interviewee 2c.12)

'I may as well do it – there's a good computer sitting in my room – the secretaries have so much to do that its quicker, yes ... but it's also good for me as I'm in control of it more' (Interviewee 2c.10).

All the nurse teachers highlighted that managerial decisions were made within a more flattened structure but this meant more meetings had to be attended. This was noticeable in the data from the interviews, in that whilst six nurse teachers stated communication with senior staff was important, this was eight less than at Stage 2a and nine less than at Stage 2b. There were mixed feelings about this. Four felt that opportunities to be involved in managerial decisions were less clear and resulted in '*more meetings than ever as you have to represent yourself so much more*'

(*Interviewee 2c.3*). Three also made reference to promotion being limited in this new organisation. In contrast, two nurse teachers preferred the managerial structure of being accountable to one Head of School and felt satisfied about the meetings to be attended.

One nurse teacher who was in a 'Principal Lecturer' post felt that, although the management was 'simpler for the staff', as the 'route director' staff were not accountable directly enough to her and this was a problem. She added:

'I have a meeting and fewer people turn up – they all seem to be doing their own thing these days' (Interviewee 2c.11)

8.6.3.5. Personal attributes

All of the nurse teachers after the merger still felt that academic experience was essential to perform the role but all recommended that available opportunities had to be self-driven (Table 8.23). The range included academic development, research development and publication profile. At Stage 2c all nurse teachers had completed a first degree (an increase of 2 from Stage 2a; Table 8.4) and four had a Master of Science or Arts degree (an increase of 1 from Stage 2a; Table 8.4), whilst a further four had registered for a 'Masters' degree (an increase of 2 from Stage 2a; Table 8.4). One nurse teacher had registered for a Master of Philosophy with the option of transferring to a Doctorate programme. This was the first teacher to follow this route. Four participants stated that reasons for further studying had been accelerated

as a direct result of the merger into higher education supporting findings at Stage 2b:

'I think being on my Masters just gives me more confidence and knowledge – I'm hopefully not only learning but keeping ahead of the times and actually though its hard work, I'm really enjoying it because in the university we have been much more supported for academic development than ever I was in the college' (Interviewee 2c.6)

'Actually through my studying I keep up to date – part of my Masters has been to undertake a clinical research project so I had to get clinical time in my contract so I could do my project – this has had lots of benefits because I have found I feel more confident about researching and publishing which I didn't before – also we weren't really encouraged in the college as it was more of a work ethic as opposed to an academic philosophy' (Interviewee 2c.14)

Interestingly, a shift was also noted that, although a majority felt in higher education that they would continue to develop their academic profiles, the need to undertake research or publishing activities was less. Two participants suggested reasons for this:

'Although support appears very good if you want to undertake research, I realised over this year that we can't all do it and I for one don't really want to at this stage in my career. Actually, I am doing some clinical contract work which I prefer ...' (Interviewee 2c.5)

'You know we all got in a panic about having to research and having to 'publish or perish' but I don't feel under pressure to do either – I'm actually too busy on a day to day basis and I think that's very well understood by my manager' (Interviewee 2c.4)

At Stage 2c, ten nurse teachers felt that communication with colleagues was required to perform their current role, this was five less than at Stages 2a and 2b. Twelve lecturers had moved office, eleven of which had moved to a different site

across the area and eight were sharing with new colleagues. Eight of these participants complained that office space, in comparison to working in a college in the NHS, was limited, some had three other colleagues in an office, whilst two felt that office space was adequate but noisy at times for example during tutorials.

The interviews revealed that the merger into University A had required the nurse teachers to:-

- Use academic opportunities (10)
  - an increase of 10 from Stage 2b (Table 8.14)

- Use networking skills (9)
  - an increase of 8 from Stage 2b

- Be autonomous (9)
  - an increase of 4 from Stage 2b

- Be positive (8)
  - an increase of 3 from Stage 2b

- Be motivated (6)
  - an increase of 2 from Stage 2b

The need to be creative (8) (new concept) and hard-working (5) was felt to be important whilst adaptation skills was felt to useful by twelve participants, the same is Stage 2b (Table 8.14). Fourteen participants referred to a sense of isolation (new concept). The frequency with which this was mentioned ranged from once to five times in a single interview including the following views:

'You do a lot more on your own – we have the school meetings and team meetings but I feel I do a lot by myself for myself these days' (Interviewee 2c.7)

'One problem is that I feel some days I could be murdered here in my office and no one would know! I just get on with my own thing when I'm at the University' (Interviewee 2c.3)

'Sure we have lots of meetings, even more at a strategic level but I feel that does mean there's little commradery like it used to be – on my site I don't even have a coffee room so whenever I see any of my old colleagues I pounce on them desperate for conversation or gossip!' (Interviewee 2c.10)

One suggestion to overcome the problems included;

'You have to get out there and make more of an effort with our own colleagues now – I think more on an individual level about how I can improve things for my students, the clinical staff I liase with, my modules I run and myself – I go to more conferences – you have to – and I probably make a bit more effort to find out about conferences and groups – otherwise in this model which is quite isolating you would go mad' (Interviewee 2c.13)

8.6.3.6. Most important versus negative attributes of role

Responses to the *'most important versus most negative attributes of role'* were analysed (Table 8.24). Nurse teachers felt that the most important current attributes were the ability to have nursing experience to link theory and practice (4/15), having autonomy and freedom in the role (4/15), possessing a positive personality (4/15), to possess academic/research abilities (2/15), to use effectively communication pathways (1/15) and to draw upon their teaching experience to develop nursing students (1/15). It was interesting to note that such findings were also found by Harri (1997) in her questionnaire survey of 65 nurse teachers after the merger into higher education in Finland.

Table 8.24.
Most important versus negative attributes of role after the merger (Stage 2c)

Most Important Attributes	Responses	Negative aspects	Responses
Nursing Experience	4	Diversity of demands	4
Autonomy/ Freedom	4	Increased workload	3
Positive personality	4	Isolation	3
Academic/research abilities	1	Lack of time (clinical)	3
Teaching experience	1	Keeping up to date	2
Communication Skills	1		

Problematic attributes of role at this stage was the diversity of demands upon nurse teachers (4/15) and increased workloads (3/15) which related to previous findings, as identified, relating to secretarial/administration support, increased meetings to be attended and increased marking. Comments included '*the larger groups we are expected to teach and supervise'* and that the diversity of the role was *'greater since the merger'*. Others suggested the isolation (3/15), lack of time to develop clinical skills (3/15) and a lack of time with respect to keeping up to date (2/15) contributed to their negative attributes. Barton (1998) also found similar findings and suggested that such role attributes were additionally hampered by a lack of adequate resources and support. Three noted that the increased isolation of working within a university establishment was the worst aspect of the role (3/15).

8.6.4. Future Role Attributes

None of the nurse teachers were unsure about their personal future in higher education at this stage of the study (Table 8.25). Indeed, this line of questioning

revealed that whilst only four nurse teachers felt that having nursing experience would be required for the future role, ten felt that it was more important to link theory to practice (whoever performed the role).

This was an interesting change of perception from previous stages and clearly related to feeling less anxious and more settled in the university structure:

'We spend such a lot of time in this university developing and teaching modules over the last year. ...Whilst I feel that's useful I hope in the future that I will be given more opportunities to develop my nursing expertise as I feel I'm really missing out on my own personal skills. I think now we are settled in here we ought to argue for this role to be developed more' (Interviewee 2c.2)

'I feel its getting harder to really encourage the nursing skills of students therefore I feel in the future we need to really push for clinical skills to be developed in our future role – it may mean ours or that we develop better partnerships with clinical staff or develop roles such as the lecturer-practitioner so we can help the students in a more pragmatic way' (Interviewee 2c.9)

'I go to the clinical area every week and I don't feel in the future that nursing experience will count for much in this higher education culture – you only have to look at some of the educational adverts to see our future and in relation to our clinical skills I feel the future's bleak I'm afraid' (Interviewee 2c.5)

'I feel I have really good contacts with the clinical areas from when I was a Nurse Tutor in the college but as time goes on I worry about these especially if new staff come into higher education for a career. I think therefore we should keep those links alive and healthy so to speak not only for us personally but for the relationship we have at the interface of the clinical areas. We have to carve out new clinical roles for ourselves and I'm not sure than means working myself on the ward with students ' (Interviewee 2c.12)

All of the fifteen nurse teachers felt that academic qualifications would be an essential future role attribute and ten added that undertaking research and/or publishing would also be expected. As a result of the merger nurse lecturers felt that

they would need to carve out a new autonomous role (13/15), which required using more adaptation strategies (13/15), such as wider networking skills (11/15), new teaching strategies (9/15) and have greater cultural awareness of other professions than nursing (10/15) (Table 8.25). This was viewed positively:-

'I feel since coming into the university I have really had to adapt more and do things by myself more – whilst I feel a bit on my own these days I feel in the future that this will be the accepted role and will require nurse tutors to develop a new role as a result – probably more strategic about work distribution and teaching commitments' (Interviewee 2c.7)

'Though I still don't know that many new people in this university I hope in the future as we develop we get many more contacts both in this university and elsewhere ... in nursing and wider allied professionals ...' (Interviewee 2c.15)

'I feel the future role will be a case of pushing yourself more – in other words selling yourself and developing a distinct area of expertise so if we really want to strengthen our role we have to attempt to do this – be less of an all rounder and more of an expert' (Interviewee 2c.8)

Table 8.25. Expected Future Role in Higher Education at Stage 2c.

Future Attributes	Responses
Academic Qualifications	15
Autonomy	13
Adaptation Skills	13
Networking Skills	11
Theory/Practice skills	10
Wider cultural awareness	10
Research & Publishing	10
Teaching skills	9
Nursing Expertise	4

8.6.5. Cultural and Organisational Understanding of Higher education

After the merger all participants identified that the new culture of University A had created new opportunities for the nurse teachers' role. Using the data as outlined elsewhere responses fell into four categories (Table 8.26).

Table 8.26.

Key cultural and organisational attributes of University A at Stage 2c

Participant	Rules	Communication	Work Organisation	Curricular Developments
1.	Clear formal rules and learning informal rules	Autonomous working patterns with flattened structure – but power distribution unequal - *'jobs for the boys'*		Academic delivery very different as now modular with an increased emphasis on level higher levels
2.		Understand channels of communication and authority – Isolation is high as spread over larger distances	Resources for teachers generally better such as email, computers and classrooms	Much improved choice for students – more flexible modules at a variety of levels
3.	Communication improved but still unsure of everyone's roles and who to contact for what Isolation high.	More autonomy, personal development and networking externally and with other professions		Curricular delivery such as modular and more wider choice but larger group size and some disparity between schools within university
4.	Clearer about rules and organisation structure – power covert not overt		Better resources and facilities (and departments such as personnel)	Greater academic developments
5.	Clearer - definitely more flexibility but climate of disparity = those who shout loudest get the most!	Clear leaders but more flattened structure (less hierarchical but those who have senior positions may have more power)	Better teaching facilities – but not secretaries	Academic higher awards and levels greater

6.	Clear work patterns but role still unclear in higher education culture	More autonomous – more flexible but have to shout up Isolation is a real problem		Clear choices and development policy Larger student groups and less awareness of seeing students progress
7.	Clear about classroom role but unsure about clinical role within university structure	Flattened structure with definite organisational responsibilities	*Much improved teaching and library resources for us*	Improved choice delivery therefore demanding and problematic
8.	Aspects of role are clear e.g. responsibilities but clinical role even more unclear within culture More flexible, flattened in university	More working alone (self motivated) - have to be prepared to get out there - *the shy boys get no pies!*		Larger student groups
9.		Less emphasis on development of clinical skills (staff and students) and quality due to large numbers of students	Some areas very developed, such as personnel, but secretarial and personnel services there is a staff shortage	Clear academic goals within a modular delivery with clear quality assurance and validation events
10.	Flexible rules – Clear patterns	Less 'professional nursing gossip' due to increased autonomy and lack of nursing emphasis	Good teaching resources	Clearer development across academic levels
11.	Nurse teachers' role - pressure to perform is quietly greater	Have clear schools within a faculty but not sure senior positions really listen or know who we are even – *Day to day work is very isolating*		More pressures to deliver
12.	Less emphasis on clinical role personally but need to be more creative in role	More autonomous so do very much as you please as long as meet teaching responsibilities		

13.	More flexible rules but still unclear role as so multi-faceted	Less hierarchical structure (but theory /practice communication channels are more problematic)		More student-centred but demands on teachers is greater to develop and deliver it all
14.	Less emphasis on development of clinical skills & role but more emphasis on academic delivery and role	Communication internally problematic due to isolation and autonomy and externally problematic due to less visible presence		Larger student groups and less awareness of seeing students through their courses from A to B.
15.	Clearer working patterns - learn as we go along about the rules both the formal and informal	Communication often breaks down as we do not see people or different sites or different work patterns. *Can be abit lonely!*	Better teaching resources	Academic developments are good – lots of choice now at higher levels but groups are too big and we are too small!

Formal and informal rules of University A appeared generally 'clear' (12) and all participants stated that they felt '*settled*'. This finding is supported in other studies about the impact of merger events on cultural understanding in other professions in that after a time in new organisations, staff begin to settle and evolve (Handy 1993, Hofstede 1994). The points made illustrate this:-

'It's been a difficult year and I'm not sure that we are still accepted by some university staff but as we go along we learn about the rules both the formal and informal which we are doing I hope it will improve' (Interviewee 2c.15)

Greater flexibility was cited in several interviews. Extracts below illustrate this:-

'There's definitely more flexibility in the culture of this university but you have to help yourself a lot more which can create a climate of disparity – those who shout loudest get the most, if you get my meaning' (Interviewee 2c.5)

'It is more flexible but the pressure to perform is quietly greater – for example I feel I should be keeping up my clinical links, running my courses and my modules, doing my supervision work, publishing, applying for courses and conferences and networking everywhere.....I have to say no-one has said this to me directly but I just feel it' (Interviewee 2c.14).

Communication pathways in University A were discussed. Whilst flattened structures were viewed positively and appeared to be accepted by the majority of nurse teachers interviewed, issues of perceived power distribution were highlighted by four respondents (Table 8.26). They felt there was different development opportunities being allotted unequally to staff and was felt by some to be less than equal as illustrated by the following:-

'I do feel that in this flattened structure a network operates of 'jobs for the boys' so to speak – it appears to me that it's all about who you know and very little research is undertaken into who is the most suitable for the job. In short those who do have the power are a minority but their use of it is actually more powerful' (Interviewee 2c.1)

'Because it's a more flexible, flattened structure if you want to get on I think you have to be prepared to get out there – in other words the shy boys get no pies! I must admit I like that myself as it drives me on' (Interviewee 2c.8)

In addition, nurse teachers were experiencing much more autonomous roles which were felt to be very positive for self-development. At the same time comments were made about the 'isolation'; some of this being geographical and some professional.

The following extract illustrates one nurse teacher's response:

'There's lots of plus factors about the autonomy we now have but one thing I miss is the 'professional gossip' – we hardly meet up as a group anymore – no-one takes lunch like we used to – and I do miss that – I think its part of our development'

Interviewer: Can you expand on this?

'I think we should have communication slots before meetings and share more – who's been to what conference and who they met such as sharing their business cards. Also staff seem to be doing research but we never really talk about it – it's a shame' (Interviewee 2c.10)

Organisation of work was raised by seven *participants (Interviewees 2c.2; 2c.4; 2c.5; 2c.7; 2c.9; 2c.10 and 2c.15*). Whilst six felt that there were better resources and facilities in the university these were largely teaching resources as access to secretarial personnel was indicated to be problematic by Interviewee 2c.9.

Curricular development and delivery was discussed. Curricular delivery was perceived to have improved in a variety of ways. Firstly, that the delivery of higher academic levels up to Masters Degree had resulted in changed teaching styles (*Interviewees 2c.1; 2c.4; 2c.5; 2c.8; 2c.9; 2c.10* and *2c.15*) and that there was clearer quality assurance and validation events in the modules (or courses) offered (*Interviewees 2c.1; 2c.2; 2c.3; 2c.8* and *2c.9*). Consequently, students were given improved flexibility and more choice (*Interviewees 2c.2; 2c3; 2c.6; 2c.7; 2c.13; 2c.15*).

A problem of such developments was the larger group sizes and some perceived disparity between schools within university (*Interviewees 2c.3; 2c.6, 2c.8; 2c14* and *2c.15*). Two participants felt that they were now less aware of student progression (*Interviewees 2c.6* and *2c 14*), an attribute which at Stage 2a Interviewee 14 had identified as helpful in order to develop students (quote; page 210). Five others referred to the pressures being greater on teachers (*Interviewees 2c.7; 2c.11, 2c.13* and *2c.15*). Moreover, Interviewee 2c.15 stated '*there may be lots of choice now but the groups are too big whilst we have become too small'*.

8.6.6. Personal information about higher education

All fifteen participants cited that their main source of personal preparatory information still came from their immediate colleagues and friends at both formal and informal meetings (Table 8.27). Fourteen emphasised that informal networking was essential due to the *'isolation'* felt as a result of the higher education culture and several referred to *'preserving their specialisms'* through such mechanisms. Independent reading had also now been undertaken (14/15) and their ongoing lived experience was drawn upon (15/15).

One respondent suggested:

'I definitely draw on those people I knew from before in the college but I have tried to build up many new contacts now. What I think is different is I'm my own agent.... If you want opportunities they are they for the taking but it's really up to you to grab them so some tutors are and others are not. In the colleges preparation for events was more given to you but now I feel it up to individuals themselves' (Interviewee 2c.10)

Table 8.27.
Personal Information AFTER the merger about higher education

Preparation used	Responses
Communication with immediate colleagues	15
Utilisation of own experience (research/academic courses)	15
Reading published literature (e .g . journals, newspapers)	14

Nurse teachers identified that additional personal preparation could also help to strengthen role. Several nurse teachers expressed that they would have to improve communication amongst one another (9), whilst a further six stated they would also have to learn to manage themselves more effectively in terms of time and responsibilities. This included comments such as:-

'Some teachers have adjusted well into lecturers and others are still tutors so they have not – those that have, have used the merger to their advantage but others seem very demoralised by it all –-if we are to strengthen our role then we must examine critically what our role is and be prepared to meet to discuss this. We are just so busy getting on with the job that we are not really communicating enough of what we are about and what we do best and what we would like' (Interviewee 2c.10)

8.6.7. Organisational information about higher education

In response to organisational information all the nurse teachers had attended a university-led 'formal' meeting (i.e. school and/or faculty) at some point within the year following the merger (i.e. since their interview at Stage 2b). Fourteen cited directly that the immediate line manager had also been seen on a regular basis,

whilst one felt that although the manager was available they '*did not feel the need to bother him much'*. Moreover, at this stage twelve had experienced their Individual Performance Review (IPR) with their immediate manager and all referred to this as 'very useful' and 'constructive'. In addition, specific reference was made to improved literature/emails circulated both in terms of correspondence letters (15), the university magazines (14) and study days or workshops available (9) (Table 8.28).

Table 8.28. Organisational Information AFTER the merger at Stage 2c

Type of information	Responses
Formal meetings (University/union)	15
Correspondence (from university)	15
University Literature	14
Internal Study days or workshops	9

Comments were largely positive in relation to such aspects:

'I do feel gradually we have got used to the communication of the organisation and it's very helpful to learn what's going on in other faculties and with other students across the various sites' (Interviewee 2c.13)

'It's not so direct as the college used to be but it's helpful all the same – we get lots (perhaps too many!) memos and study day opportunities which many of us have taken up' (Interviewee 2c.6)

At some point in the interview all of the nurse teachers stated that they wished that organisational preparation in higher education had been more specifically focused on nursing as a distinct specialism (12/15) and /or that nurse teachers met as a large group more often (15/15). Some of their responses are presented:

'I do feel that we are a big group spread now all over the various sites it would be useful to come together as a group. For example the university could try to put on an event such as our own conference which we could all have the opportunity to attend – not an elite chosen group of a few or even within a school or team but as large body' (Interviewee 2c.8)

'Although every department you contact is always helpful they are always faceless these days and though I know what's going on in my own school I know very little of the other nursing schools work. It would be nice to get together occasionally on a professional level to share initiatives or developments from the previous year' (Interviewee 2c.14)

8.6.8. Benefits of role in higher education

Perceived benefits of working in higher education as nurse teachers included the facilitation of developing the professional base of nursing (15/15) and increased networking opportunities (11/15) (Table 8.29). The 'flattened' structure of the university was also perceived to be an advantage (8/15) along with opportunities to develop personal (12/15), academic (13/15) and research/publication profiles (4/15). Eight responses were identified where nurse teachers stated that in higher education they 'enjoyed' more satisfaction relating to job contract terms, whilst four transcripts stated that perceived 'job status' was better as a result of their title as lecturers in a university.

Table 8.29. Perceived benefits of working in higher education at Stage 2c

	Number of responses
Develop professional base of nursing	15
Further academic development	13
Self personal development	12
Increase networking opportunities	11
Flattened organisational structure	8
Terms of Contract	8
Increased 'job' status	4
Research / publication development	4

Such responses included:

'I hoped, and to a certain extent feel that it has happened, that through this merger nursing would be brought more into the public arena in a positive way, such as better qualifications, advancing nursing practice and ultimately increased professional status' (Interviewee 2c.10)

'I really feel that my own self- development has taken off in higher education –I've been given more study opportunities. I'm much more focused in what I do and less trying to be a 'jack of all trades' which we used to be' (Interviewee 2c.5)

'I'm pleased with my salary and the terms of my contract generally – sure you always need more but I think we negotiated a fair deal at this university' (Interviewee 2c.3)

8.6.9. Problematic issues of role in Higher Education

Nurse teachers suggested that their clinical nursing skills were less developed since transferring into higher education (15/15) and the consequences of that were a wider theory / practice gap (14/15) (Table 8.30). Thirteen referred to problematic role issues in large organisation including '*nursing not valued*', '*not distinct*' and '*not being in the NHS*'. Twelve also suggested that there were increased demands,

examples of which include an increased amount of marking (11/15), meetings (9/15) and general administration (8/15). In addition, variety of teaching (12/15) and changed teaching style due to large group teaching (8/15) was viewed as problematic and added to pressure as identified in other questions at Stage 2b.

Other comments related to feeling a sense of isolation (7/15), unclear information or a lack of direct communication (2/15) and an increased autonomy in their own decision–making but less autonomy in the organisation (3/15). It was, however, interesting that the nurse teachers felt that the research and academic demands (3/15) were considered less problematic than at Stages 2a and 2b. One nurse teacher commented:-

'There's a lot more hidden pressures on us now I think ... I mark a lot more work and there's much less back up if for example someone goes off sick or lets you down – In the college we all used to bail out so to speak but not now' (Interviewee 2c.5)

Table 8.30. Perceived Problems of role in Higher Education

	Responses
Loss of clinical/nursing skills	15
Wider theory / practice gap	14
Nursing value	13
Increased role demands	13
Variety of teaching	12
Change of Teaching Style	8
Isolation	7
Research/academic pressure	3
Autonomy	3
Unclear information/communication	2

Interview data was examined as to the patterns of role conflict and was found to have reduced substantially since the previous Stage 2b. Largely, nurse teachers had taken up their positions in university and settled into positions as 'lecturers'. As identified in Barton (1998), participants in this study, now felt less anxious than previously reported at Stage 2b. It appeared that there were still conflicts related to role expectations and responsibilities especially with respect to clinical expertise and clinical role, such as whether they should have a clinical role or not. Time to develop clinical expertise was still viewed as a low priority in higher education institutions and potential for role conflict remained as follows:-

'We definitely feel further away from the clinical areas than in the college. We are not on site for one thing and at the moment the theory and practice interface relies on old relationships which we made from the college days but I do worry how this will all go in another few years time' (Interviewee 2c.4)

'I think this role has more freedom and development but its problems are bigger workloads, more lonely and more pressures' (Interviewee 2c.15)

8.7. Summary of Stage 2

At Stage 2c it was felt that the longitudinal framework used across all stages had been a useful and logical approach. The information collected was interesting and helped to build up a picture of fifteen nurse teachers as they evolved in their roles in one HEI.

The literature had highlighted that whilst nurse teacher role had been explored prior to the merger, there was limited work of the nurse teacher role following the merger into HEIs. One aspect of the nurse teachers' role attributes that had emerged out of the pre-merger literature was that of 'curriculum development'. In the study reported, it was observed from the outset of emerging findings at Stage 2 that this finding conceptually differed to the pre-merger literature. In this study, this finding emerged not out of the actual role attributes, but as a feature of the cultural and organisational attributes (Tables 8.7, 8.17 and 8.26). There may be several reasons for this, which will be discussed fully in the discussion chapter (Chapter 11). Suffice to say role concepts, from which findings can be summarised at this stage included:

- Classroom role
- Student role
- Clinical role
- Managerial / administration role
- Personal attributes

Using this framework, findings were also compared for similarities and changes in numbers of responses from one stage to another (Table 8.31).

Table 8.31. Overall key role attributes compared across Stages 2a, 2b and 2c

Role Attribute	Stage 2a	(n=)	Stage 2b	(n=)	Stage 2c	(n=)
1. CLASSROOM ROLE	Development of students (classroom)	**15**	Development of students (classroom)	**15**	Development of students (classroom)	**15**
	Teaching skills	**10**	Teaching skills	**8**	Teaching skills	**9**
	Linking theory to practice (Classroom)	**9**	Linking theory to practice (Classroom)	**7**	Linking theory to practice (Classroom)	**14**
2. STUDENT ROLE	Communicating with students	**15**	Communicating with students	**15**	Communicating with students	**6**
	Supporting/ counselling students	**8**				
			Development of students	**15**	Development of students	**15**
3. CLINICAL ROLE	Communicating with clinical staff	**15**	Communicating with clinical staff	**9**	Communicating with clinical staff	**6**
	Nursing Expertise	**15**	Nursing Expertise	**12**	Nursing Expertise	**11**
	Linking theory to practice (Clinical)	**12**	Linking theory to practice (Clinical)	**9**	Linking theory to practice (Clinical)	**4**
	Clinical credibility	**12**	Clinical credibility	**8**	Clinical credibility	**5**

4. MANAGERIAL/ ADMINISTRA-TION ROLE	Administration /managerial – marking correspondence meetings course organisation	**9**	Administration /managerial – marking correspondence meetings course organisation	**7**	Administration /managerial – marking correspondence meetings course organisation	**15**
5. PERSONAL ROLE ATTRIBUTES	Communicating with colleagues	**14**	Communicating with colleagues	**15**	Communicating with colleagues	**10**
	Communicating with senior managers	**14**	Communicating with senior managers	**15**	Communicating with senior managers	**6**
	Academic Experience	**11**	Academic Experience	**15**	Academic Experience	**15**
	Adaptation skills	**6**	Adaptation skills	**12**	Adaptation skills	**12**
	Positive Role Model	**3**	Positive personality Positive role model	**10** **5**	Positive Role Model	**8**
	Autonomy	**2**	Autonomy	**5**	Autonomy	**9**
	Questioning skills	**2**	Questioning skills	**3**	Questioning skills	**3**
	Motivation	**3**	Motivation	**4**	Motivation	**6**
	Networking	**1**	Networking	**1**	Networking	**9**
					Creativity	**8**
					Hard working	**5**

Overall, Table 8.31 demonstrates that whilst some role attributes did not change such as development of the students in the classroom and the need to communicate with students, other attributes did show change. Some of the notable examples included the administration role which appeared to rise considerably after the merger whilst linking of theory to practice in the clinical areas and communicating with clinical staff decreased. Some attributes were also felt to be needed at Stages

2b and 2c, such as, the need to possess adaptation skills (12/15) whilst the need to network and be hard-working were attributes at Stage 2c only. These issues will be drawn together and expanded upon in Chapter 11.

With respect to 'role conflict' witnessed it was also noted that whilst this was high at Stage 2b, at Stage 2c, this appeared to have reduced and a new nurse teacher role was being developed. This appeared to incorporate some of the role attributes identified in the previous role of nurse teachers in the colleges of nursing as outlined in the literature review (Chapter 3) and indicated in Table 8.31. Such noted changes may be due to the response of nurse teachers to what they believed were the expected new role attributes required by the university. It would then follow that some reduction of role conflict would occur because by Stage 2c the culture of higher education was more clearly understood by the nurse teachers.

However, there still existed unclear role attributes at Stage 2c in terms of expected clinical role. Indeed, the need for this role and how best to adapt this role in higher education culture resulted in a range of mixed responses. Some nurse teachers felt the clinical role should be developed, whilst others felt that the new role for the nurse teacher should be at a strategic partnership level. This dichotomy was also highlighted in the classroom role where the majority of nurse teachers felt that they were in a prime position to teach the 'theoretical underpinnings of care' but yet equally did not feel they wanted to teach clinical based skills.

By Stage 2c, cultural and organisational understanding of nurse teacher role in higher education had increased overall, and so for most of the nurse teachers aspects such as formal and informal rules were largely accepted. Having clear cultural understanding appeared to lead to the commonly used phrase of 'role opportunities' (or the lack of them). This related to organisational opportunities such as promotion, flexibility of work hours, job status, being involved in managerial decisions and developments such as academic, research, publishing, networking, contacts and autonomy.

Communication featured at all stages, both when discussing students (individually and groups), clinical staff, colleagues and senior educational staff. Whilst this attribute of the role was generally valued, problems of communication at Stage 2c included the large group sizes and the organisational model of University A. This may in part be due to the isolation of working in higher education institutions which many nurse teachers identified in terms of geographical location of staff and increasing allotted personal workloads / responsibilities which resulted in a lack of time.

Overall, the nurse teachers had *'settled'* with respect to titles and job contact expectations. However, whilst there was acceptance of the 'lecturer' title at an organisational level, there remained some personal issues about the group of nurse teachers calling themselves 'nurse lecturers'. This was noted especially when they had conversations with clinical staff and begs the question as to whether this relates to acceptance by the nurse teachers or acceptance by the clinical staff.

However, whilst some nurse teachers appeared to be more aware and accepting of higher education culture, others preferred to carry out the role organising their work as in the previous culture of the nursing college. This clearly related to 'perceived benefits', one noticeable example being organisational structures, which some nurse teachers had embraced and others had not. Interestingly, at Stage 2c there also appeared to be disparity of academic development as some of the nurse teachers appeared to have 'enjoyed' more opportunities than others. This appeared to relate in part to a mixture of self-drive and individual personality.

In the study reported here, whilst the sample size was small, rich data was collected at all stages; before, at and a year after the merger event. As a result of the framework, different responses could be identified at strategic points and any changes could be analysed in depth. The next set of interviews was Stage 3, which included the clinical staff perceptions of nurse teacher role after one year of the merger into higher education.

Chapter 9

Stage 3 Findings

9.1. Introduction

At Stage 3, a purposeful, convenient sample of 20 qualified, clinical nurses were interviewed one year after the merger of nurse education transferring into higher education. The purpose of interviewing this group was to explore their perceptions of nurse teachers' role as a result of the merger.

As outlined in Chapter 6 (Section 6.4), Hospitals A, B and C were used at Stage 3 of the study reported, each being NHS Trusts serving the needs of adults, children and mentally ill adults. The sample included 12 clinical nurses from Hospital A, five from the children's setting of Hospital B and three from the mental health setting of Hospital C. As part of their teaching and supervision role all the clinical nurses had all come into contact with a variety of nurse teachers from University A.

A semi-structured interview style with prompts was devised (Appendix 9) and the adopted framework for analysis is outlined in Chapter 7, but is presented below in Table 9.1. Interviewees are identified as 3.*1 to 20*.

Table 9.1.Themes used for Clinical Nurse Interviews at Stage 3

	Theme title
1.	Contextual information
2.	Perceptions about the merger into higher education
3.	Perceptions of the nurse teacher role in higher education
4.	Communication issues with nurse teacher

9.2. Contextual information

All 20 clinical nurses at Stage 3 were required to supervise or 'mentor' students as part of their role. They were generally clear in the expectations of the role, fifteen stating that this was a direct 'one to one' role and five stated that they undertook this indirectly in a team approach. Two participants stated that this indirect role of supervision had emerged as a result of their own '*increasing job responsibilities*' (*Interviewees 3.12* and *3.18*)

Four respondents referred to '*enjoying*' supervision of students but one highlighted how '*difficult*' this could be to undertake when having to work alongside students for a period of two days per week. She stated that the mentoring system '*can just fall down overnight if the student requests a day off or a study day ...we do our best but it' s sometimes challenging to say the least' (Interviewee 3.16).* Another respondent referred to student expectations versus reality, which they felt was a particular problem of supervision:

'The tutors write these competency documents and the students arrive with them and they are sometimes just impossible to complete because they are full of jargon or the student's expectations are so far from the reality...' (Interviewee 3.1).

9.3. Perceptions about the merger into higher education

It was important to ascertain the clinical nurse's understanding of the merger event prior to discussing specific role attributes of nurse lecturers. Clinical staff perceptions about the impact of the merger of nurse education into higher education revealed a mixture of feelings (Table 9.2).

Table 9.2.
Clinical staff perceptions about the merger into higher education on nurse training

Response	Benefits	Problematic
Professionalism of nursing	15	0
Theory versus practice gap	1	14
Educational Opportunities	14	1
Greater Pressure	2	13
Skill development	0	12
Supernumerary status	3	11
Facilities for students	10	5
Academic qualifications	9	6
Course Content	7	5
Course development & entry issues	6	4
Research development	9	6

Generally, responses indicated a positive view about the drive into higher education developing nursing in relation to professional status (15/20), that the students generally had better facilities in the university (10/20) and that more educational

opportunities would be available as a result of nurse education transferring to higher education (14/20). This is illustrated as follows:

'This merger has to be better in the long run for us as a profession – when we trained it was really a functional task-orientated training and we were totally service led students ... but now the students should get more opportunities than we did ... and they will be better for it ... more confident and yes a different breed and that can only be good' (Interviewee 3.19)

'I for one do not want the good old days back ... they were not good old days ...they were often difficult ...nursing being university based has to be much better ... my worry is that the Trust staff will creep back in to try to influence things too much and the university must stand firm for the students sake...' (Interviewee 3.17)

Other positive responses were also obtained in relation to the impact of the merger, such as better academic qualifications (9/20) and greater research development (9/20). Overall, clinical staff felt that such developments would contribute to greater professional status of nurses and would add to potential career opportunities for student nurses.

Interviews also indicated that, although clinical staff were aware that the colleges had amalgamated into the universities less was known about specific details and reasons for the merger. Generally responses were as follows:-

'I understand that all nurse training is now organised through the university as part of the drive for an all graduate profession ... all students are now supernumerary and it's more theoretically focused than when I trained' (Interviewee 3.7).

'I would say that I was not particularly informed about the specific politics of the merger but I am aware that all the colleges merged into one another then merged into the university and largely that's where the bulk of pre and post training occurs in this city' (Interviewee 3.20)

One staff nurse (*Interviewee 3.6*) spoke of how when she trained she always felt '*second best'* because she trained at one of the colleges in the area that *'was not considered to be as a elitist as the others'*. She had always felt that this was an issue when she went to work as a staff nurse at some of the hospitals outside her original training school. She commented:

I'm not sure but there must be more parity now as the large bulk of students come from University A. This must have reduced that rivalry which used to covertly exist. Sure there must be still some between the new universities and old, red brick universities but it has got to be better overall'.

Fourteen participants specifically mentioned the notion of supernumerary status, eleven of which stated that they had reservations about students being supernumerary as they '*never really experience the real world of nursing' (Interviewee 3.4)*. One paediatric ward manager (*Interviewee 3.15*) felt very strongly:

'S*ome students manipulate the supernumerary status'*. She cited several examples where she had '*bent over backwards to give students their mentors, not add the students into the numbers and allow additional study opportunities'*.

She went on to say that it later upset her and her ward staff when she:

'*Discovered that the students had been milking the system in that they stated they had study days when they did not have or in their evaluations stated that they had not worked with their mentors when it was actually them who had requested the day off.*

She felt that this in part was due to the lack of communication between University A and wards but was also in part due to national confusion that surrounded what supernumerary status really entailed.

Problematic responses were also indicated in relation to a perceived theory versus practice gap (14/20) (Table 9.2). Thirteen nurses felt that pre-registration students were under greater academic pressure to perform so demands and expectations were high of them, and as a consequence twelve felt that students' actual nursing skills (or the ability to perform them) was subsequently less. Several nurses stated that they had reservations that content was more theoretically based than practically based so also contributed to pre-registration students lacking in clinical based skills. However, data also highlighted that participants repeatedly referred to the lack of clear focus with respect to the development of clinical skills of pre-registration student programmes organised not only at University A but also nationally. Although the sample is small this finding is indicative of the suggestions made about the problems of skill development in the widespread national consultation report, known as The Peach Report (UKCC 1999) as discussed in Chapter 2.

In part this related to not knowing the organisation of courses and the content to be delivered as *'one university is very different from another so if I was being honest I would say I have not got a clue how the courses are specifically organised' (Interviewee 3.5).* It was also seen to relate to increasing numbers of students requiring placements and a lack of direct contact with nurse teachers from

University A. Data indicated that the length of allocations was problematic as it was felt to be too 'short'. As a consequence it was difficult to develop student skills because *'just as they are getting settled, they have to leave' (Interviewee 3.10)*. This would also support findings of the UKCC (1999) report.

Consequently, many of those interviewed stated that since the merger into higher education the theory and practice 'gap' was '*worse*'. The impact of this problematic relationship was that the nurse teacher was perceived as *'somewhat remote' (Interviewee 3.18)* and had an *'unclear role in relation to their clinical practice' (Interviewee 3.13)*. Others illustrated this in noting:-

'The world of nursing is very different at the grass roots from that experienced in the classroom. This is no different to when I trained but practice has developed so much in the last five years, and probably so has education, that actually those in academia and those in clinical areas are now poles apart' (Interviewee 3.8)

'I feel that there is a two tier system ... there are those in academia who supervise and run the courses and there those out here supervising and assessing practice as best they can ... somewhere and somehow I think we should meet as this has created a huge gap' (Interviewee 3.3)

Other respondents cited their anxieties about the theory-practice relationship through discussing students that they had encountered. Comments illustrate this as follows:-

'The new breed of student nurses (...and when they are qualified) ... are very different – they are much less practically orientated and they have limited skills for example assessment skills - which I find worrying. So I feel that more academia does not always mean better care and then we expect more of them ... such as this idea of critical thinkers and using evidence ... I think we expect too much' (Interviewee3.2)

'I do worry because some of the student nurses I come across do not really want to be 'hands on nurses'... they want more, which isn't a bad thing but their expectations are unrealistic or alternatively they are terrified and lack so much confidence ... I find over the years this is a problem ... these are very different, diverse poles on a continuum. Therefore I see less of the combination which is actually the type of student I prefer' (Interviewee 3.3)

'We should ensure a balanced programme for all students ... I don't particularly favour the good old days philosophy. Rather what we must do is re-examine nationally what the students do and do not get. What we should do to help them both as nursing and education staff, is ensure that they get the crucial skills and experience which all adds up to good nursing. That means both parties must speak to one another regularly to help the students achieve this because if we don't who will?' (Interviewee 3.14)

9.4. Perceptions of the nurse lecturer role in higher education

The clinical staff raised a number of specific issues about the nurse lecturer role. These are discussed below.

9.4.1. Title

It was of interest to record the title that clinical staff usually used with respect to nurse lecturers. All twenty called the teachers 'Nurse Tutors' at all times during the interview although seven additionally pointed out that they usually used their first names. One succinctly added that '*I have always called them this and I think I always will although I'm aware that since the merger they are called lecturers'* (*Interviewee 3.9).* Another pointed out that *'I call them tutors because that's how I think of them and it's not just because of when I trained because I have noticed that's what the new students call them as well' (Interviewee 3.11).*

9.4.2. Current role attributes of the nurse lecturer role

The clinical staff had firm views on what attributes they felt were required for the nurse lecturer role (Table 9.3). Largely, perceived attributes included being accessible (15/20), academically credible (13/20), clinically credible (14/20), having an approachable personality (11/20), being up to date (10/20), possessing good communication skills (10/20) and being supportive (9/20). Additional attributes included being innovative and creative in the role (6/20), knowledgeable in the teaching of their subject (5/20) and being motivated and enthusiastic (3/20).

Table 9.3.
Current role attributes of the nurse lecturer role as identified by the clinical staff

Attribute	Number of responses
Being Accessible	20
Academically credible	14
Clinically credible	14
Approachable	11
Must be up to date	10
Possess good Communication skills (with students and clinical staff)	10
Supportive	9
Innovative and creative	6
Knowledgeable in teaching of speciality or subject	5
Motivated and enthusiastic	3

All the clinical staff stated that accessibility to nurse lecturers was very important. The reasons given for this included:

'it's really important for me as a qualified nurse to be able to contact the tutor especially if I have a problem with a student or am unsure about an aspect of a student's training or competency document ...we have professional development staff in our hospital which is great for clinical development of students but if I want to know about an educational problem it's a tutor I want from the university; not one of them I'm afraid because at the end of the day it's the university where the student is training' (Interviewee 3.15)

'I feel access is the key to the theory / practice issues everyone talks about ... we need to be able to access one another so we know what the courses are about and where the students are coming from and the tutors should understand what it's like out here' (Interviewee 3.5)

'There's so much going on that access to tutors is crucial ... we need to be able to contact them and meet with them (and vice versa) on a regular basis' (Interviewee 3.9)

Fourteen felt that the nurse lecturers should be 'clinically credible' (Table 9.3). On questioning what this meant a range of responses were noted. Nine felt that this did not mean working on the wards but rather linking and using their teaching skills more creatively. One participant also felt that it was crucial for nurse lecturers to be '*clinically competent'*, because she stated that students had told her that they did not get enough practical skills taught by up to date teachers and that as a consequence she had noted over her four years in post that their *'practical skills were much less developed on arrival to the ward (Interviewee 3.10).* Several others reported a similar picture.

Another ward manager of a paediatric ward noted that her ward had '*got a lot busier with very dependant children on the ward whilst at the same time we expect a lot from the students even if they are supernumerary – the balance of which is very difficult' (Interviewee 3.14).* Participants felt that as a consequence of these issues it was important for them to feel that nurse teachers were developing students both in terms of practice and theory. However both of these, and nine others,

pointed out that although they did not doubt academic credibility of nurse lecturers, they had reservations about clinical credibility.

9.4.3. Future role attributes of the nurse lecturer role

The participants were asked to suggest ways in which the nurse lecturer role could develop in the future. Interview data was examined for recurring themes outlined in Table 9.4.

Table 9.4.
Future role attributes of the nurse lecturer role as identified by the clinical staff

Attribute	Number of responses
Develop models/strategies of accessibility	15
Availability	12
Have time to undertake clinical activities	14
Visits wards/units	12
Network activities (magazine, conferences, journal club)	10
Creative new posts (University /Trust)	10
Be involved in hospital (meetings, interviews)	9
Undertake clinical research work	8
Must keep clinical skills up to date	8
Joint supervision	4
Best Practice days/Sharing days	3
Be more flexible	2

A range of suggestions for future role attributes included improving and developing models of 'accessibility' with nurse lecturers and clinical staff (15/20). As part of this, participants felt that this meant nurse lecturers being more available (12/20) several citing that emails were not used enough to link as illustrated:

'We are on email now and I know they are but I hardly use it to them – I feel that I couldn't bother them – we should have a regular slot to communicate' (Interviewee 3.7)

Clinical work was discussed in all interviews (Table 9.4). Whilst eight felt that nurse lecturers should work on the wards/departments and twelve felt that 'link' role visits were useful; others felt that this could be performed more effectively. Suggestions included the development (and investment) in shared new posts between universities and trusts (10/20); nurse lecturers becoming more involved in the hospital activities both in meetings or interviews for staff (9/20) and undertaking or advising about clinical research projects (8/20) and joint supervision of named students (4/20). Fourteen felt that nurse lecturers needed to be given more time and support for such clinical activities whilst two felt that nurse lecturers should undertake clinical work in a system of 'flexible' hours such as Saturdays and evening cover.

'Some staff I know feel that they should work in the clinical area but I don't – I remember them coming onto the wards and quite frankly it was abit of a hassle– no what I want is for them to link to us more creatively ... I want to know what they seem to know ... you know conferences and research and stuff like that' (Interviewee 3.12)

'They need to be clinically credible and that depends on how they see that – it might be getting in our nursing meetings or research or interviewing senior staff or just coming to see us and being visible but they need time for this ... they seem completely busy whenever I meet one' (Interviewee 3.8)

Ten suggested that nurse lecturers could share and network both university and clinical activities better such as having a shared university / clinical magazine,

conferences and a journal club. Three participants highlighted that their NHS trust was having 'best practice days' where best practice was shared across the hospital. They felt that nurse lecturers could do the same, thus sharing educational initiatives and invite clinical staff to the university for *'best education days' (Interviewee 3.17).*

9.5. Communication with nurse lecturers

All twenty participants valued good accessibility and communication pathways between their wards/units and the educational institution of University A. Prior to the merger all the wards and community areas where interviews took place had a defined 'link tutor' (Chapter 3). Upon merging into University A it was decided that this clinical link role would change into a more strategic liaison role. Sixteen of the clinical staff referred to this *'as a loss in the communication process' (Interviewee 3.9).*

Fourteen stated that they had experienced difficulties in getting in contact with nurse lecturers since the merger into higher education. It was noted that *'lack of contact'* was increasingly problematic and the role of *'link tutor'* to the ward/unit and '*personal tutor*' to individual students had changed considerably. In contrast, three also stated that they felt that prior to the merger communication processes with nurse teachers were 'better'. In Hospital A, (which had been opposite the college of nursing) many of the clinical nurses made reference that communication

was made 'worse' because the nurse lecturers were not 'on site' (University A campus was a mile away). Two stated:-

'In the college we used to iron out what was happening on the ward versus what was being delivered in the classroom – things were dealt with much more quickly and in a humanistic way ... I mean we knew who they were and who to ring ... and of course they were on site to help us and come and see us and we could pop to see them if we needed to ... now ...forget it ... its too far to trudge over to the university' (Interviewee 3.6).

'Tutors used to be much more on site but now access to them is very problematic – when I have had to contact them it takes ages to get through although actually when I have they have always been very supportive' (Interviewee 3.16).

In addition, it was stated that access to information about courses via nurse lecturers was viewed as more problematic than when nurse training was in the college of nursing in the NHS. This was especially true in view of the increased range of courses and large student groups. Comments illustrate this point:-

'Seeing a tutor these days is rare – and I think it's crucial that we do have access to them' (Interviewee 3.11)

'The only contact I have from tutors is on the phone, via the students or from the students' competency documents' (Interviewee 3.20)

'I know tutors from the college days but I hardly see them these days' (Interviewee 3.13).

'well there a distinct lack of focus now – we used to criticise the link role but all I can say now is well at least they used to visit us and we knew how to contact them but I feel now that role has gone there is a distinct lack of focus to all' (Interviewee 3.18)

Four of the areas had hospital trust 'practice based teacher' posts paid for by the trust to support staff and students. Another ward had a lecturer practitioner post, which was jointly organised by University A and the hospital trust. All interviewees

on these areas felt that students were well supported by these individuals. However, probes to determine the expected role of nurse lecturers on these areas revealed that interviewees still wanted some form of direct contact from University A.

One ward manager stated the following:-

'the clinical teaching sister is excellent – supportive and works well with students but I must say its all in isolation if the tutor who runs the course comes no-where near ...'

Upon being asked what communication she would like from nurse lecturers she replied,

'Anything creative at all like attending joint meetings, visits, regular feedback, letters and ...more preparation about the students and the documents – well anything because it's all better than we have now' (Interviewee 3.7)

Thirteen participants were aware of a newly proposed strategy at University A which was known as 'Clinical Liaison Teams' which aimed to develop specific named links to strategically support staff and students of University A. All thirteen hoped that this would improve communication with nurse teachers as illustrated:-

'I have been informed that there will be a clinical liaison team in every trust who will communicate with that trust at a strategic level and with ward staff directly – I think that's good' (Interviewee 3.19)

'I think that's very useful as I still believe in seeing tutors here at the work face so to speak – it says a strong message about valuing practice and linking theory to practice I think. Maybe I'm old fashioned but I like to see or talk directly to people so that I can have a one to one conversation about a query or a problem' (Interviewee 3.10)

'I hope this will improve our communication with the tutors and will help us to understand more about the courses and competency documents – such aspects can only be good because it does concern me that in this current model where communication is less then good then aspects like competency document signing which has always been problematic only gets worse' (Interviewee 3.9)

Interviewees were asked how and whom they would contact if they had an educational problem or question. Responses highlighted a distinct lack of information about communication pathways to University A. and although several clinical staff had referred to communication and accessibility as problematic, once this was overcome tutors had been supportive and helpful.

One Ward Sister on an acute medical ward referred to an experience that she had had in which two weeks previously, a student on her ward had a drug calculation problem and was very nervous about giving out medications. The Course Director of the student's programme was notified and, although it had taken four days for her call to be returned, once it was a '*tutor came very quickly to help this particular student' (Interviewee 3.6)*. The Ward Sister stated that '*staff were worried about a tutor coming along and so was the student ... but when she did, she was so helpful and supportive to us all ...she handled it brilliantly'*. Other interviewees supported this view similarly:

'Recently, we did have a problem and I rang the allocations department and they put me onto the right person – when she came the problem was dealt with very well but getting in touch with the right person at the right time was terrible' (Interviewee 3.2)

'Well, I'd speak to the ward manager and ring tutors that we knew but it's really hard work getting in touch with tutors these days – it seemed bad in the college days but this is much harder because they are geographically much further away now' (Interviewee 3.13)

9.6. Summary of Stage 3

The clinical nurse interviews were useful in order to 'build up' the picture of the nurse lecturer's role as a result of nurse education transferring into HEIs. It was noted that the clinical nurses were clear about their role as supervisors to students on placement and that nurse education was delivered in universities. They were however less clear about the merger, the nurse lecturer's title and educational strategy at University A. Consequently, many felt that since the merger into higher education the theory and practice 'gap' was '*worse*'.

Alternatively, the clinical nurses hoped that the merger would enhance nurses' academic qualifications and greater research development. In so doing they hoped that this would develop nursing as a profession. With respect to University A they also hoped that students would enjoy better facilities and educational opportunities than in the college of nursing. However, it can be argued that much of this was an *'untested assumption'* given that the clinical nurses' knowledge of nursing courses in University A appeared limited.

Overall, the clinical nurses felt that it was a key attribute of the nurse lecturers' role to inform clinical staff about their educational programmes. However, the biggest problem of this process appeared to relate to a lack of communication. On this point, there were strong indications that the clinical nurses interviewed wanted more contact and accessibility to nurse lecturers. Moreover, they felt that

communication with them had become 'worse' since the merger into higher education and that nurse lecturers were more geographically isolated from them (and vice versa). This would seem a major challenge for nurse lecturers who are based in a university that may be some distance from the hospitals that they link with and send their students to.

From this small sample it was felt that developing better communication pathways should be central to the role of nurse lecturers and that time and support should be given to this. Moreover, it was felt that this could re-addressed through developing creative partnerships, some in existence and some for the future. In the context of educational reform (UKCC 1999) such outcomes would seem essential. These issues will be further expanded in Chapter 11.

Chapter 10

Stage 4 Findings

10.1. Introduction

The qualitative data reported in Chapters 7, 8 and 9 gave insights into the experiences of one group of 'nurse teachers' over the transition period. However, this data originated from one university (University A) and three hospital trusts associated with that university (Hospitals A, B and C). The findings were thus specific to that culture and those nurse lecturers employed in University A. Thus, there was a need to determine whether the experiences reported were typical of all nurse lecturers at this time. Consequently, Stage 4 of the study was designed to address this wider issue and explore views of nurse lecturers in other institutions, who had undergone a similar institutional merger twelve months previously.

In order to meet the aims of the study (Chapter 1; Section 1.1.1), a questionnaire was developed using 'key phrases' derived from the interview data from Stages 2 and 3 (Appendix 11a, 11b). Wider literature pertaining to nurse lecturer role and merger events theory (Clifford 1995a, Luker et al 1993, Barton 1998, Day et al 1998, Sackmann 1991, Hofstede 1991) was also used. Stage 4a included a test-retest method to develop the questionnaire (Section 6.6.2.2). Subsequently, the questionnaire used at Stage 4b collected both qualitative and quantitative data (Appendix 10b). The quantitative data included a satisfaction/importance scale, which is a research technique that has been used in other health care sector studies and has been found to have great potential in evaluating respondents' views (Johnson et al 1988, Werrett et al 2001, Carnwell &

Moreland 1999, 2000). Further detail about the questionnaire design can be found in Chapter 6 (Section 6.6.2.2).

10.2. Response to the questionnaire (Stage 4b)

The questionnaire was circulated to 140 nurse lecturers across two additional universities (University B and C). As identified in Table 10.1, 100 questionnaires were circulated to University B and 40 to University C. Overall, returns totalled 98, a response rate of 70%. University B resulted in 74 respondents of 100 sampled (74%) returning their questionnaires within the given time-scale, whilst University C yielded 24 respondents of 40 sampled (60%).

Table 10.1. Sampling frame and response

Institution code	Estimated Number of staff	Total circulated	Total Returned	%
University B	142	100	74	74
University C	42	40	24	60
	184	**140**	**98**	**70**

Hague (1993) notes that any response rate over 60% must be considered to be successful for a questionnaire, as often the response rate is below 50%. The high overall total response in this study was largely due to the process organised in Universities B and C. Key individuals from both University A and B offered their help and as they both held senior positions in the organisation they offered to send their own supportive letter with the covering letter and questionnaire (Appendix 10a, 10b). Furthermore, although this cannot be substantiated the use

of the internal post system in their institutions may have been more convenient for individuals to return questionnaires. Bell (1993) suggests that internal mailing systems help to 'personalise' the project and so could potentially increase the response rate.

Initially the response from University C was only 18 of the 40 sent (45%). Oppenheim (1992) and Bell (1993) suggest that the researcher should consider what to do about non-responses before the questionnaires are sent. Whilst a date record was kept of when the questionnaires were distributed and when they were returned, the researcher was not aware of which staff had been sent questionnaires. Therefore, in order to ensure parity a letter was sent to the identified contacts at both universities, which was then circulated to the same staff that had been targeted in the first round. They were given a further two weeks additional time, which generated no further responses from University B and a further six questionnaires being returned from University C (n=24). A decision was made not to pursue the non-responders further as the total response can be seen as high for a questionnaire (Oppenheim 1992).

10.3. Questionnaire analysis

The reliability of the quantitative scales of the questionnaire was determined by a coefficient alpha of 0.83 indicating a high reliability. As discussed in Chapter 6 (Section 6.10), the quantitative data was subjected to analysis by Microsoft Excel and SPSS (Foster 1993). Quantitative data was subjected to descriptive statistical analysis being represented as numbers or percentages as indicated. Qualitative data has been categorised and presented in descriptive format. The

findings from each section of the questionnaire are presented below with brief explanations.

10.4. Questionnaire findings

10.4.1. Career plan/biographical profile of nurse teachers

Background information was ascertained in questions 1-4 (Appendix 10b). The majority (89%) of respondents were aged between 31 and 50 years old with 60% being between 41-50 years and 29% between 31-40 years. In addition 9% were over 51 years and no respondent was under 30 years of age (Table 10.2). Table 10.3 shows that 41% of the respondents had worked in nurse education between 11 and 15 years and 29% between 7 and 10years.

Table 10.2. Age of nurse lecturer respondents

Option of age groups	**Actual numbers (n= 98)**	**%**
< 30 years	0	0
31- 40 years	29	30
41- 50 years	60	61
> 51 years	9	9

Table 10.3. Length of time in education of nurse lecturer respondents

Option of years	**Actual numbers (n= 98)**	**%**
< 3 years	0	0
3 years – 6 years	14	14
7 years – 10 years	28	29
11 years – 15 years	40	41
>15 years	16	16

10.4.2. Reasons for entering nurse education

Table 10.4 demonstrates that the most common reason for entering nurse education as a career choice was that the nurses enjoyed teaching (71%). Other commonly cited reasons included academic development (31%), to be a positive role model (29%), self development (20%) and because of being advised to by other nurse teachers. Although less prevalent, it was also clear that there were other reasons for entering nurse education including the opportunity to undertake research (6%), autonomy (6%) and convenient hours (3%).

Table 10.4. Reasons for entering nurse education

Reasons for entering nurse education	**Actual number (n =98)**
Enjoyed teaching	70
Academic development	30
Role Model	28
Self Development	20
Advised to	10
Opportunity to research	6
Autonomy	6
Convenient Hours	3
Other comments added	
Wanted to do a better job	4
Influence care and practice	4
Better pay	2
Link theory and practice	2
Good experience	1
Useful in career structure	1
Overcome own fears	1

10.4.3. Qualifications: Professional, Academic and Teaching

Nurse lecturer qualifications are divided into professional nursing qualifications, academic and teaching qualifications. It is acknowledged that nurse lecturers may hold other qualifications such as clinical courses, but those reported were felt to be most relevant to the study reported here.

10.4.3.1. Professional nursing qualifications

Findings showed that all of the respondent group were Registered General Nurses (RGN), while 16% were Registered Mental Health Nurses (RMN), 8% were Registered Sick Children's Nurses (RSCN) and 4% were Registered Nurses for People with Learning Disabilities (RNMH) (Table 10.5). In terms of community qualifications 13% were Health Visitors and 8% held a District Nursing Certificate. Whilst the sampling frame did not include midwifery teachers (Chapter 6; Section 6.5), 2% held the qualification but stated that they were working as 'nurse lecturers'.

Table 10.5. Professional nursing qualifications of the sample
(Note – Some respondents had more than one qualification)

RGN (Adult nursing)	**RMN (Mental Health)**	**RMNH (Learning Disability)**	**RSCN (Children's nursing)**	**Other**
98 (100%)	16 (16%)	4 (4%)	8 (8%)	Health Visitor = 13 (13%) District Nursing Certificate = 8 (8%) Midwife = 2 (2%)

10.4.3.2. Teaching qualifications

All the nurse lecturers in the sample had a recognised teaching qualification. Some appeared to have more than one teaching qualification, as indicated in Table 10.6. Whilst 57% had a Registered Nurse Teacher (RNT) qualification, 22% also had a Registered Clinical Nurse Teacher (RCNT) qualification and 38% had a City and Guilds 730 Teaching and Assessing course. In addition, 15% had a Certificate in Education (CertEd), which was integral part of their first degree, and 9% possessed a Post-graduate Diploma in teaching.

Table 10.6. Teaching qualifications of the sample

Registered Clinical Nurse Teacher (RCNT)	**Registered Nurse Teacher (RNT)**	**Certificate in Education (integral with degree)**	**Post graduate Diploma**	**City & Guild 730**
22 (22%)	56 (57%)	15 (15%)	9 (9%)	37 (38%)

10.4.3.3. Academic status

All of the nurse lecturer respondents had a first degree (Table 10.7). Of these, 45% had obtained a Master's degree whilst 16% had registered for one. Three per cent had obtained a Master of Philosophy whilst a further 4% had registered for one. Two percent had a Doctor of Philosophy degree and a further 2% were registered for one. Overall, this meant that 72% of the nurse lecturers had or were registered for higher degrees as can be seen in Table 10.7.

Table 10.7. Academic status of the sample

Academic Course	Obtained	Registered
1st degree e.g. BA; BSc	98 (100%)	0
Masters Degree e.g. MSc, M.A.	44 (45%)	16 (16%)
Master in Philosophy (M.Phil)	3 (3%)	4 (4%)
Doctorate in Philosophy (PhD)	2(2%)	2 (2%)

10.4.4. Current Job Title

Nurse lecturers were given the option to indicate their title noted in their present job contract (Appendix; Question 5). The most frequently identified title was that of 'Senior Lecturer', which accounted for 74% of the respondents and 'Senior Lecturers in Nursing' were a further 17% (Table 10.8). Only 4% of respondents stated that they were 'Principal Lecturers'. No respondents indicated they were 'Lecturers in Nursing' or 'Lecturer Practitioners'. Three percent answered in the 'other' column, one as a Principal Lecturer in Nursing and two as Course Leaders. The respondents' choice of 'current title' would seem to relate to the HEIs accessed in this study, as both University B and C were 'new' universities as highlighted previously in Chapter 5 (Section 5.4.3.1).

Table 10.8. Current Titles of nurse lecturers

Current titles	Actual numbers (n= 98)
Lecturer in Nursing	0
Lecturer Practitioner	0
Senior Lecturer	74
Senior Lecturer in Nursing	17
Principal Lecturer	4
Other	3

Respondents were also given options about the title they used on the telephone to clinical staff (Appendix; Question 6) (Table 10.9). The diversity in responses identified that some confusion existed about the acceptance of 'new' titles. Twenty eight percent of the respondents stated that they used 'Senior Lecturer' and 26% used their own name on the phone. Overall, 16% used 'Nurse Tutor', 8% used 'Nurse teacher', 7% used 'Senior Lecturer in Nursing', 4% used 'Lecturer in Nursing' and no respondent used 'Principal Lecturer'. Those responding in the other categories included 'Link Tutor' (4%) and 'Branch Leader' (5%).

Table 10.9. Title used on the telephone

Options	**Actual numbers (n =98)**
Senior Lecturer	27
Own name	25
Nurse Tutor	16
Nurse Teacher	8
Senior Lecturer in nursing	7
Lecturer in Nursing	4
Principal Lecturer	0
Other Link tutor Pathway/Branch leader	4 5

10.4.5. Current Role attributes

Current role attributes were explored in question 8.0, using ways of comparing importance against satisfaction (Appendix 10b). Much consideration was given to how best to measure the findings from this part of the questionnaire, within the range of tests available. It is worthy to note that question 8.0 has a five-point

scale for the satisfaction/importance issues that emerged out of Stage 2 and 3 findings (Appendix 10b).

In measuring satisfaction/importance, Green & D'Oliveira (1999), suggest that the 'mid scale point' can be omitted from the range of calculations. This was undertaken in the study reported (Points 1 and 2 represented low scores whilst points 4 and 5 represented high scores). Johnson et al (1988) suggest that satisfaction can be plotted against importance in a scale format, but added that this is problematic if the sample is small. The response in this study to the questionnaire at Stage 4b was 98 and was therefore small, so a decision was made that descriptive statistics would be most useful using percentages for the current role attributes, which focused on questions related to classroom, student, clinical, managerial /administration and personal attributes.

Within each theme total scores were added together as whole and from this the mean was calculated. The range of was also calculated in each of the focused groups. Finally satisfaction/importance was plotted against each other using clusters of findings and presented in a scatter-plot graph for each theme group. Each current role attribute theme will be discussed below.

10.4.5.1. Classroom role

The classroom role of nurse teachers was explored in questions 8.12; 8.20 and 8.21 (Appendix 10b). The findings presented in Table 10.10 show the focus of these questions related to the variety and styles used in the classroom role.

Table 10.10. Nurse lecturer classroom role attributes

		1	2	3	4	5	
8.12. Variety of teaching	**LS**	15 (15%)	29 (30%)	24 (25%)	26 (27%)	4 (4%)	**HS**
	LI	0	0	10 (10%)	37 (38%)	51(52%)	**HI**
8.20. Teaching formal lectures	**LS**	9 (9%)	22 (22%)	25 (26%)	30 (31%)	12 (12%)	**HS**
	LI	0	11(11%)	9 (9%)	33 (34%)	45 (46%)	**HI**
8.21. Teaching in seminars	**LS**	13 (13%)	19 (19%)	14 (14%)	31 (32%)	21(22%)	**HS**
	LI	0	0	0	42 (43%)	56 (57%)	**HI**

Key = LS = Low satisfaction; LI = Low importance
HS = High satisfaction; HI = High importance

As indicated in Table 10.10, all of the nurse lecturers felt that variety of teaching commitments was an important attribute, and a large number responded that, whilst this was important to them, they were not satisfied with this aspect of the role.

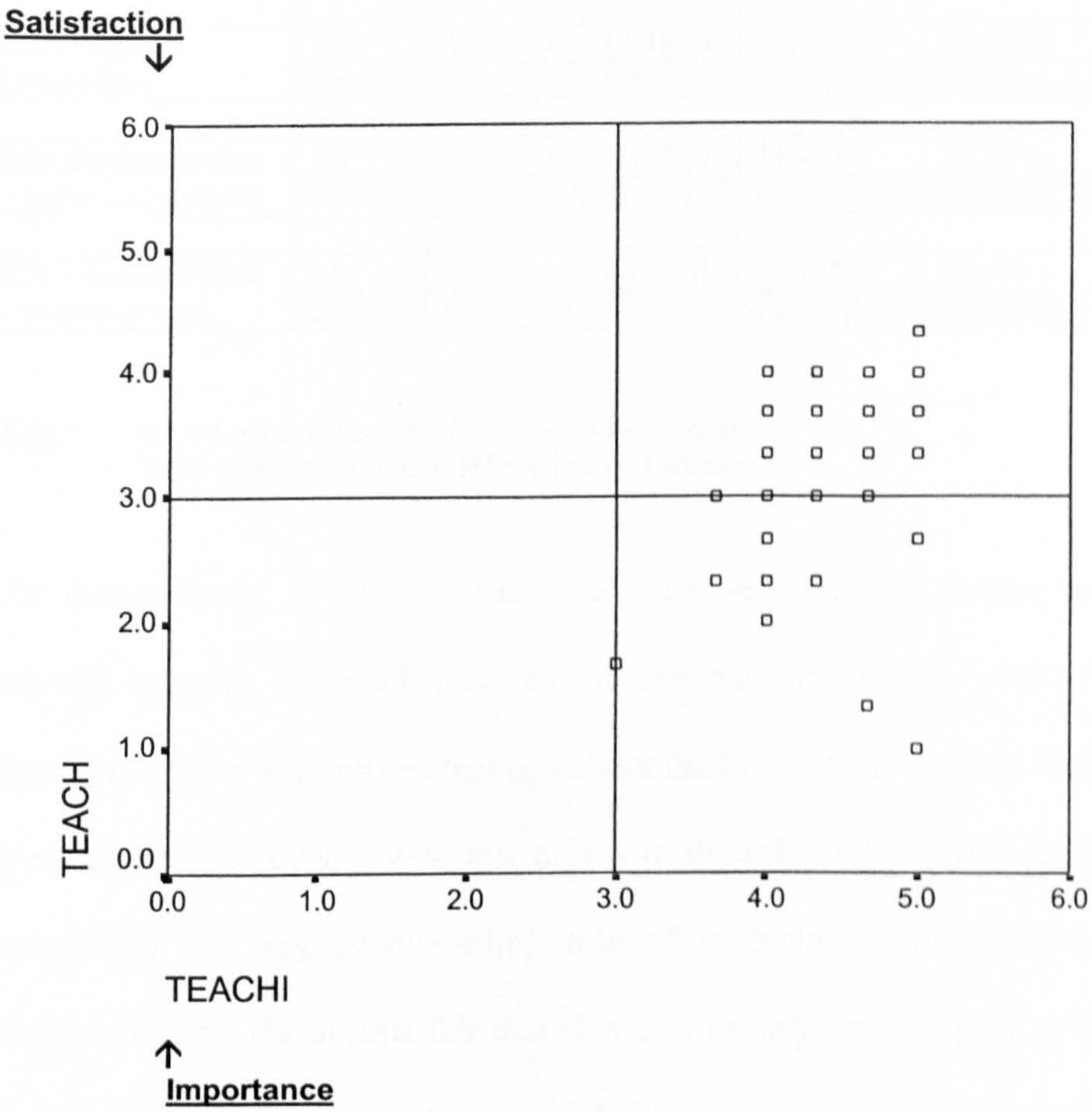
As highlighted in Table 10.10, teaching students in formal lectures was viewed as an important role attribute (80% overall) although some dissatisfaction was indicated. Overall, all respondents indicated that seminar teaching was also very important in their role although some role dissatisfaction was noted.

The mean and range of the findings in this group are presented in Table 10.11 below. No data was missing from the questionnaire in this group (n=98), the mean score satisfaction was 3 and for importance it was 4. Figure 10.1 represents this diagrammatically showing that whilst overall importance of classroom role attributes was high satisfaction was average.

Table 10.11. Mean and range scores of classroom role attributes

		Satisfaction	Importance
1. Classroom role attributes	**Valid**	98	98
	Missing	0	0
	Mean	3.0578	4.3776
	Range	3.33	2.00
	Minimum	1.00	3.00
	Maximum	4.33	5.00

Figure 10.1. Satisfaction/importance of classroom teaching role attributes



10.4.5.2. Student role

Student role was explored as part of the current nurse lecturer role, which included questions 8.18; 8.22; 8.23 and 8.24 (Appendix 10b) and results are presented in Table 10.12.

Table 10.12. Nurse lecturer student role

		1	2	3	4	5	
8.18. Supervision e.g. tutorials	**LS**	18(18%)	19(19%)	26(27%)	22(22%)	13(13%)	**HS**
	LI	0	0	7(7%)	35(36%)	56(57%)	**HI**
8.22. Support/ Counselling	**LS**	16(16%)	18(18%)	33(34%)	22 (22%)	9(9%)	**HS**
	LI	0	5(5%)	6(6%)	17(17%)	70(71%)	**HI**
8.23.Communication – individual students	**LS**	11(11%)	24(25%)	21(21%)	28(29%)	14(14%)	**HS**
	LI	0	0	0	39(40%)	59(60%)	**HI**
8.24.Communication – student groups	**LS**	8(8%)	19(19%)	25(26%)	35(36%)	11(11%)	**HS**
	LI	0	0	15(15%)	28(29%)	55(56%)	**HI**

Key = LS = Low satisfaction; LI = Low importance
HS = High satisfaction; HI = High importance

As demonstrated in Table 10.12, the nurse lecturers' responses to student tutorial support indicated that, whilst the majority (93%) viewed this as important, there were mixed feelings about the level of satisfaction. Whilst 37% were dissatisfied overall with this aspect of the role, 35% were satisfied. With respect to the support/counselling role of students by nurse lecturers also indicated that 87% overall felt that this was an important aspect of the nurse lecturer role. However, satisfaction related to support/ counselling was divided.

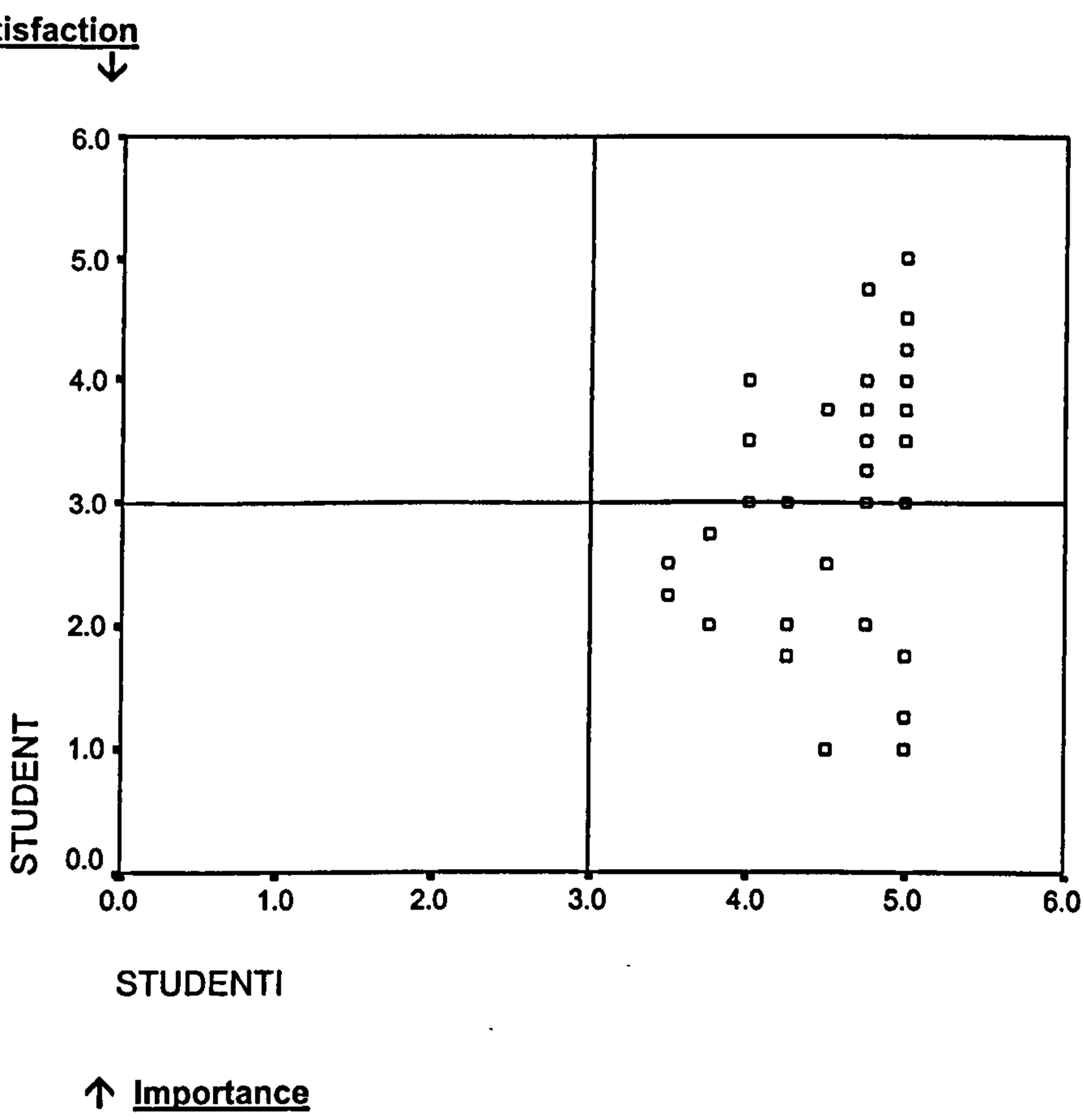
As indicated, all the nurse lecturers felt that communication with individual students was either important or very important. Eighty five per cent also indicated that communicating to students groups was either important or very important. There were, however, mixed levels of satisfaction with respect to both these aspects of expected role.

With respect to this group, no data was missing from the questionnaire in this group (n=98). Mean and range scores of the group findings are presented in Table 10.13 below. The mean importance was high (4.5) whilst satisfaction was three. Figure 10.2 represents this diagrammatically showing that overall importance was high whilst satisfaction of student role attributes was average.

Table 10.13. Mean and range of student role attributes

		Satisfaction	Importance
2. Student role attributes	**Valid**	98	98
	Missing	0	0
	Mean	3.0383	4.5153
	Range	4.00	1.50
	Minimum	1.00	3.50
	Maximum	5.00	5.00

Figure 10.2. Satisfaction/importance of student role attributes



10.4.5.3. Clinical role

The clinical role of nurse lecturers was explored with respect to clinical visiting, communication with clinical staff, opportunities for keeping clinical skills up to date and time given for clinical work. The questions included 8.1; 8.2; 8.3 and 8.28 (Appendix 10b) and results are presented in Table 10.14.

Table 10.14. Nurse lecturer clinical role attributes

		1	2	3	4	5	
8.1. Opportunities to develop clinical skills	**LS**	32(33%)	35(36%)	18(18%)	9(9%)	4(4%)	**HS**
	LI	6(6%)	0	18(18%)	25(26%)	49(50%)	**HI**
8.2. Visiting students on placement	**LS**	22(22%)	46(47%)	14(14%)	9(9%)	6(6%)	**HS**
	LI	0	0	2(2%)	18(18%)	78(80%)	**HI**
8.3. Communication with clinical staff	**LS**	10(10%)	44(45%)	28(29%)	12(12%)	3(3%)	**HS**
	LI	0	0	0	26(27%)	72(73%)	**HI**
8.28. Time given to develop clinical skills	**LS**	46(47%)	17(27%)	23(24%)	7(7%)	5(5%)	**HS**
	LI	6(6%)	6(6%)	6(6%)	22(22%)	59(60%)	**HI**

Key = **LS = Low satisfaction; LI = Low importance**
HS = High satisfaction; HI = High importance

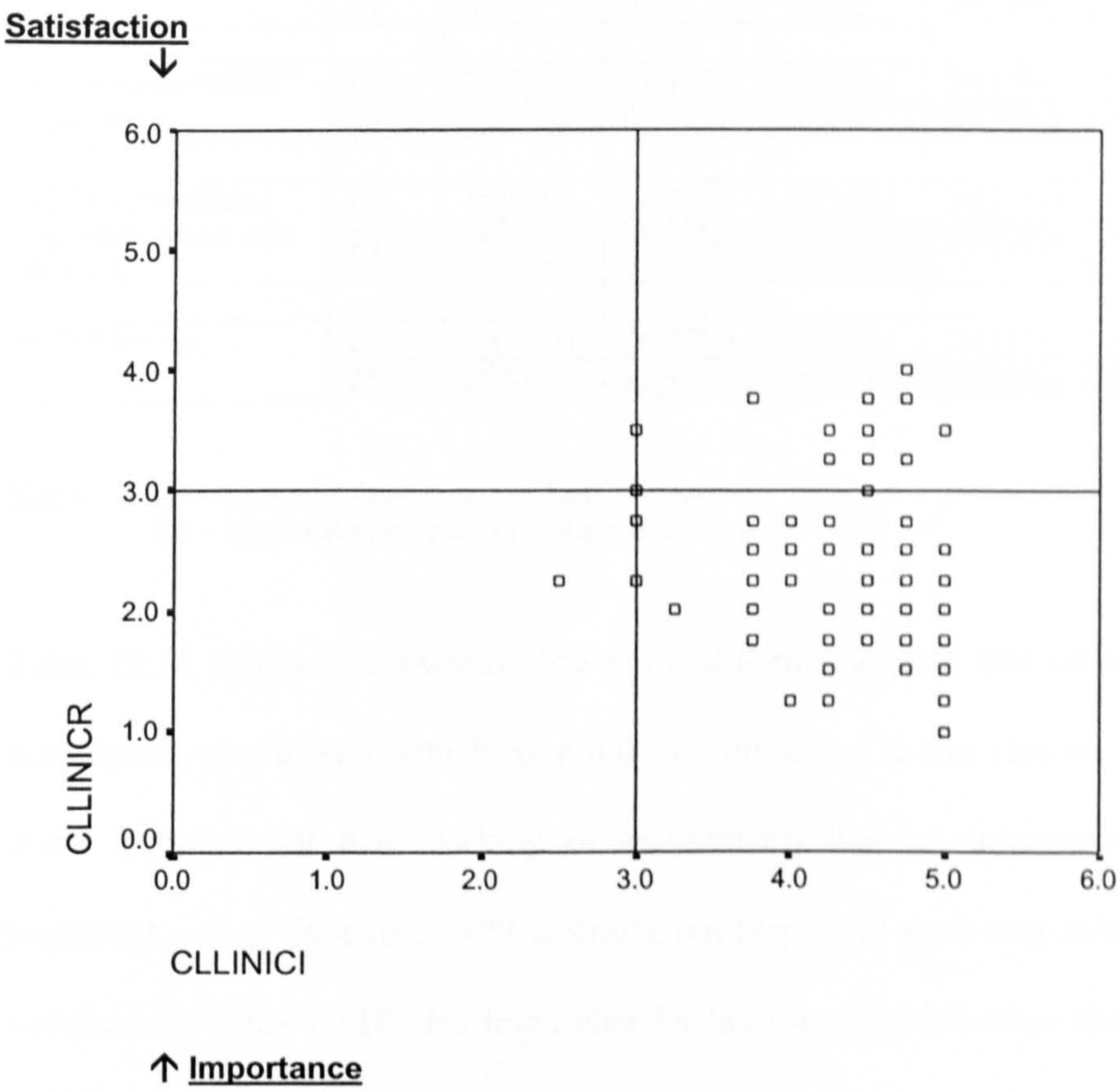
Table 10.14 highlights that opportunities to develop clinical skills were viewed as important and very important by 65% of respondents but there was considerable dissatisfaction about this aspect of the role (69%). It can also be seen that dissatisfaction was high (69%) with respect to visiting students on placement whilst importance was high (98% overall). Communication with clinical staff was viewed as important by all respondents overall with mixed responses of satisfaction. Time given for clinical work produced very interesting results and worthy to note, in that, whilst 82% felt that this was important some did not.

With respect to clinical role attributes, no data was missing from the questionnaire in this group (n=98). The mean and range scores of these findings as a group are presented in Table 10.15 below. The mean importance was high at 4.5 whilst satisfaction was very low at 2.2. Figure 10.3 represents the mixed responses diagrammatically.

Table 10.15. Mean, range, minimum and maximum scores of clinical role attributes

		Satisfaction	Importance
3. Clinical role attributes	**Valid**	98	98
	Missing	0	0
	Mean	2.2577	4.4668
	Range	3.00	2.50
	Minimum	1.00	2.50
	Maximum	4.00	5.00

Figure 10.3. Satisfaction/importance of clinical role attributes



10.4.5.4. Managerial and Administration Role

Questions 8.15; 8.17; 8.19; 8.27 and 8.30 related to managerial and administration aspects of the nurse teacher role (Appendix 10b). Results are presented in Table 10.16.

Table 10.16. Nurse lecturer managerial and administration role attributes

		1	2	3	4	5	
8.15. Administration	**LS**	8(8%)	14(14%)	26(27%)	25(26%)	25(26%)	**HS**
	LI	0	0	12(12%)	15(15%)	70(71%)	**HI**
8.17. Marking	**LS**	17(17%)	29(30%)	29(30%)	21(21%)	2(2%)	**HS**
	LI	0	0	6(6%)	34(35%)	58(59%)	**HI**
8.19. Course/module organisation	**LS**	22(22%)	17(17%)	27(28%)	24(25%)	8(8%)	**HS**
	LI	0	0	3(3%)	28(29%)	67(68%)	**HI**
8.27.Correspondence e.g. letters, phone calls & emails	**LS**	15(15%)	21(21%)	27(28%)	26(27%)	9(9%)	**HS**
	LI	1(1%)	12(12%)	21(21%)	28(29%)	36(37%)	**HI**
8.30. Meetings	**LS**	30(31%)	26(27%)	28(29%)	11(11%)	3(3%)	**HS**
	LI	2(2%)	19(19%)	45(46%)	23(24%)	9(9%)	**HI**

Key = LS = Low satisfaction; LI = Low importance
HS = High satisfaction; HI = High importance

Table 10.16 shows that, overall 86% felt that administration was important but satisfaction was mixed, which may indicate disparity. It can also be seen that nurse lecturers felt that marking of assignments was an important or very important part of their role (94% overall), but responses were very mixed about satisfaction. Table 10.16 also highlights further mixed satisfaction views about course/module organisation as this was viewed as important by 97% of respondents. Results relating to the amount of correspondence, such as letters, emails or phone calls, indicated that, whilst nurse lecturers felt that this was important in their role (66%), here again satisfaction responses were mixed.

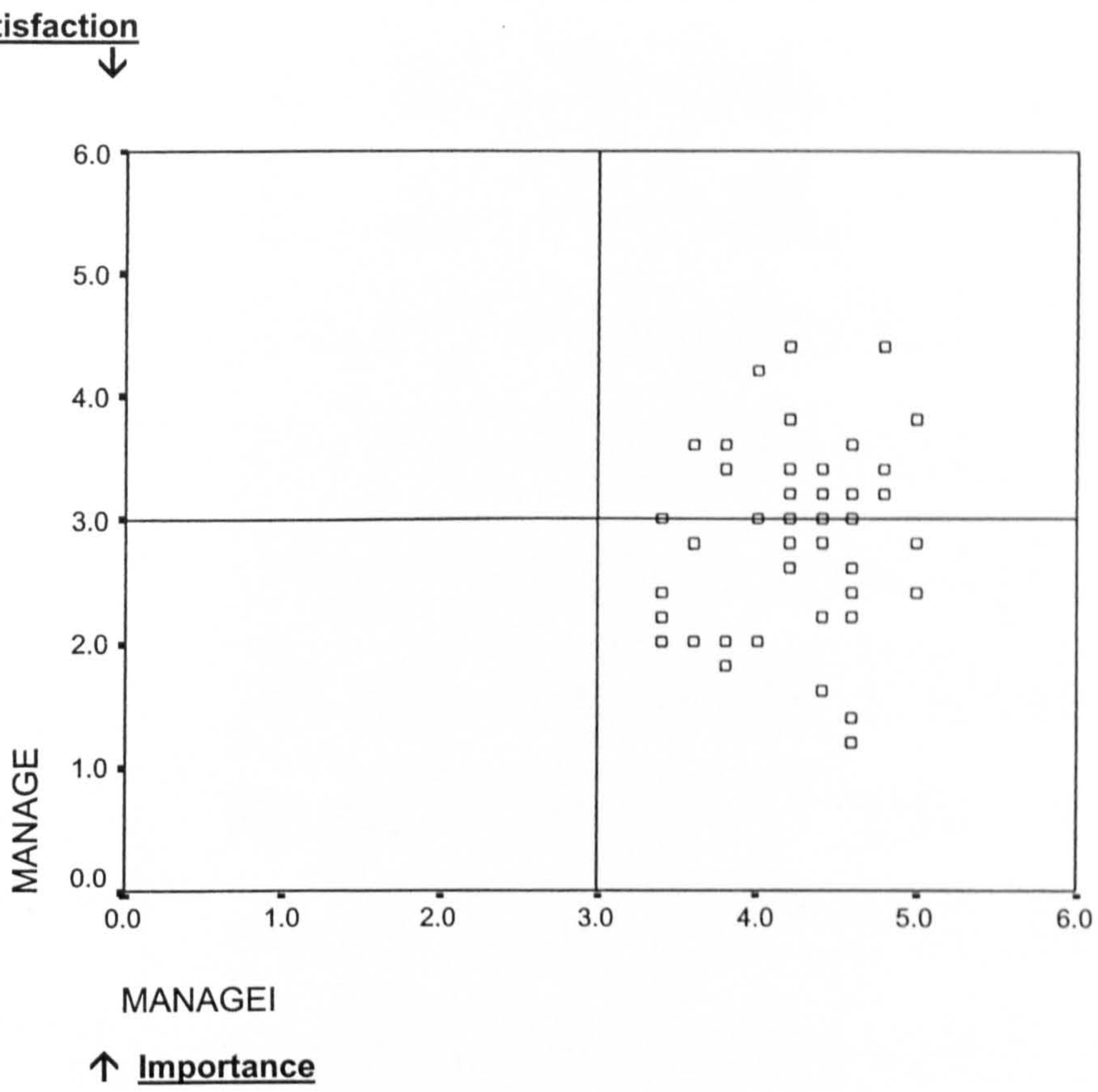
Furthermore, feelings were mixed about the meetings that nurse lecturers attended. As indicated in Table 10.16, whilst some nurse teachers felt that attending meetings was an important aspect of their role (32%), others did not (21%). Satisfaction was again variable.

With respect to managerial role attributes, no data was missing from the questionnaire in this group (n=98). The mean, range and minimum scores of these findings as a group are presented in Table 10.17 below. The mean importance was high at four, whilst satisfaction was low (2.8). Figure 10.4 represents the responses diagrammatically.

Table 10.17. Mean and range scores of managerial role attributes

		Satisfaction	Importance
4. Managerial role attributes	**Valid**	98	98
	Missing	0	0
	Mean	2.8163	4.1694
	Range	3.20	1.60
	Minimum	1.20	3.40
	Maximum	4.40	5.00

Figure 10.4. Satisfaction/importance of managerial role attributes



10.4.5.5. Personal Attributes

Personal attributes with specific reference to communicating with senior staff and colleagues, role autonomy, job contract, office space, job status, flexibility and time given to undertake the nurse teacher role were issues from the interview data. In questions 8.9; 8.10; 8.11; 8.13; 8.14; 8.16; 8.25; 8.26 and 8.29 such issues were explored (Appendix 10b). Results are presented in Table 10.18.

Table 10.18. Personal attributes used in role

		1	2	3	4	5	
8.9. Communication with senior staff	**LS**	19(19%)	36(37%)	29(30%)	5(5%)	9(9%)	**HS**
	LI	1(1%)	1(1%)	23(23%)	27(28%)	46(47%)	**HI**
8.10. Appraisal	**LS**	33(34%)	16(16%)	18(18%)	22(22%)	9(9%)	**HS**
	LI	1(1%)	0	20(20%)	22(22%)	55(56%)	**HI**
8.11. Autonomy	**LS**	14(14%)	12(12%)	11(11%)	45(46%)	16(16%)	**HS**
	LI	0	1(1%)	5(5%)	35(36%)	57(58%)	**HI**
8.13. Job contract	**LS**	1(1%)	5(5%)	21(21%)	42(43%)	29(30%)	**HS**
	LI	0	3(3%)	11(11%)	22(22%)	62(63%)	**HI**
8.14. Office space	**LS**	12(12%)	13(13%)	7(7%)	27(28%)	39(40%)	**HS**
	LI	0	1(1%)	17(17%)	21(21%)	59(60%)	**HI**
8.16. Status as a lecturer	**LS**	1(1%)	8(8%)	28(29%)	38(39%)	23(23%)	**HS**
	LI	10(10%)	7(7%)	29(30%)	30(31%)	22(22%)	**HI**
8.25Communication - work colleagues	**LS**	15(15%)	30(31%)	15(15%)	18(18%)	20(20%)	**HS**
	LI	0	0	8(8%)	21(21%)	69(70%)	**HI**
8.26. Flexibility	**LS**	7(7%)	10(10%)	14(14%)	22(22%)	45(46%)	**HS**
	LI	0	1(1%)	9(9%)	23(24%)	65(66%)	**HI**
8.29. Time to undertake role	**LS**	46(47%)	28(29%)	11(11%)	13(13%)	0	**HS**
	LI	0	0	2(2%)	25(26%)	71(72%)	**HI**

Key = **LS = Low satisfaction; LI = Low importance**
HS = High satisfaction; HI = High importance

Communication with senior faculty staff was explored as part of performing the role effectively. As indicated in Table 10.18, 75% of the nurse lecturers felt that this was an important aspect of the role. Along with senior staff communication, appraisal was also explored. Whilst importance was high (78%) satisfaction was mixed between those highly satisfied and highly dissatisfied with respect to both these aspects of role.

As illustrated, in Table 10.18, autonomy of role was also important to the respondents (overall 94%), but whilst 62% were satisfied with aspects of

autonomy in their role, 26% were not. With respect to the nurse lecturers' job contract in HEIs, overall 73% appeared satisfied, and indeed 85% viewed this as important. Eighty one percent overall viewed their office space as important and 68% were satisfied. However 25% indicated that they were not satisfied possibly indicating some disparity.

'Job status' was explored and findings showed that overall, nurse lecturers were satisfied with their 'job status' (62%) and some felt that was important to them (53%). This may indicate that nurse teachers have settled into higher education 'role status'.

As shown in Table 10.18, a large majority of the sample felt that it was important to communicate with other nurse teachers (91% overall), but satisfaction was mixed whereby 38% were satisfied whilst 46% were not. As the pattern of satisfaction was evenly distributed this could indicate that some nurse teachers did communicate, whilst others did not.

In total, 90% felt that flexibility of work was important and response indicated high satisfaction (68% overall). As there was largely a high level of satisfaction and importance about flexibility of the role this could indicate that nurse lecturers had settled in their work patterns in the two universities.

However, 76% were dissatisfied with the amount of time available to undertake role duties and indeed no respondent was 'very satisfied'. Conversely, 98% of the nurse teacher sample felt that having time to undertake role was important with a large group (72%) stating that this very important. As dissatisfaction was

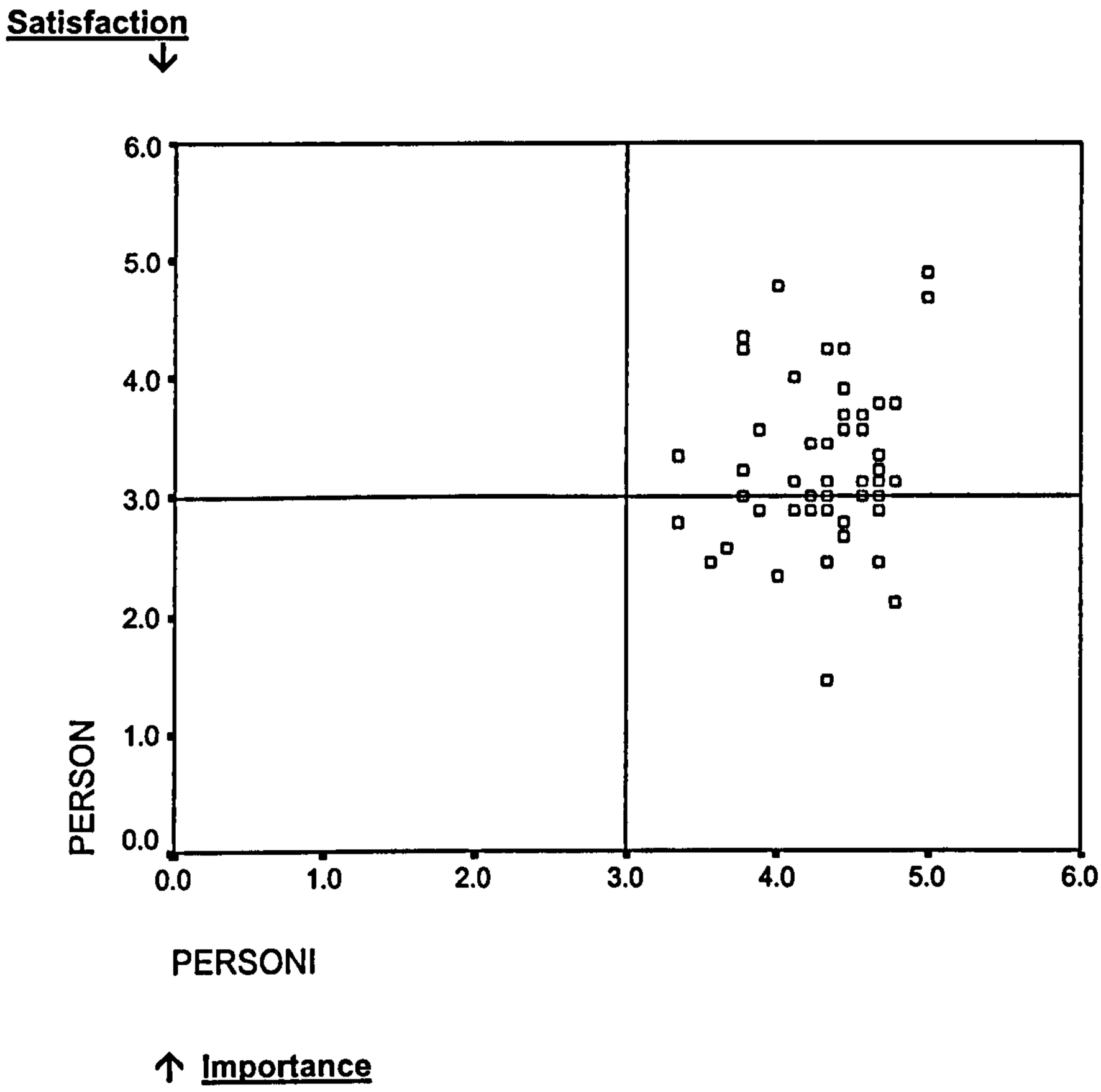
high this may indicate that nurse lecturers experience conflict with the time given to undertake the expected managerial and administration duties.

The mean, range and minimum scores of personal role attributes are presented in Table 10.19 below. No data was missing from the questionnaire in this group (n=98). The mean importance was high at four, whilst satisfaction was three. Figure 10.5 illustrates the mixed responses diagrammatically.

Table 10.19. Mean and range scores of personal role attributes

		Satisfaction	Importance
5. Personal role attributes	**Valid**	98	98
	Missing	0	0
	Mean	3.1791	4.3605
	Range	3.44	1.67
	Minimum	1.44	3.33
	Maximum	4.89	5.00

Figure 10.5. Satisfaction/importance of personal attributes in role



10.4.5. Future role attributes

Future role attributes were explored in relation to opportunities to develop and were included in several questions (8.4; 8.5; 8.6; 8.7 and 8.8). Results are presented in Table 10.20.

Table 10.20. Nurse lecturer future role attributes

		1	2	3	4	5	
8.4. Academic opportunities	**LS**	10(10%)	8(8%)	23(23%)	28(29%)	29(30%)	**HS**
	LI	0	6(6%)	10(10%)	18(18%)	64(65%)	**HI**
8.5.Research opportunities	**LS**	9(9%)	24(25%)	36(37%)	14(14%)	15(15%)	**HS**
	LI	0	3(3%)	30(31%)	33(34%)	32(33%)	**HI**
8.6.Publication opportunities	**LS**	16(16%)	21(21%)	40(41%)	13(13%)	8(8%)	**HS**
	LI	1(1%)	6(6%)	32(33%)	30(31%)	29(29%)	**HI**
8.7.Managerial opportunities	**LS**	27(28%)	41(42%)	18(18%)	4(4%)	8(8%)	**HS**
	LI	0	2(2%)	7 (7%)	48(49%)	41(42%)	**HI**
8.8.Networking opportunities	**LS**	19(19%)	19(19%)	27(28%)	23(23%)	10(10%)	**HS**
	LI	1(1%)	1(1%)	16(16%)	34(35%)	46(47%)	**HI**

Key = LS = Low satisfaction; LI = Low importance
HS = High satisfaction; HI = High importance

Overall, as shown in Table 10.20, 59% of respondents were satisfied with academic development in the higher education system and 83% felt it was important. Eighteen percent were, however, dissatisfied and it is of interest to note that those respondents who were 50 years old and above, all ticked in columns 1 and 2.

Given this result, opportunities for 'research development' was interesting as this was viewed as an important role attribute by 67%, but it is worthy to note that 3% did not feel it was important. Furthermore, 34% were dissatisfied with the research development opportunities, whilst 29% were satisfied. This may

indicate disparity in that some nurse lecturers are given opportunities to research whilst others do not feel that they are given enough.

The opportunity to develop a nurse lecturer publication profile was explored. Overall, 60% felt this was important, but it was found that, whilst 37% appeared dissatisfied with their publication profile, 21% were satisfied. Table 10.20 also highlights that opportunities to be involved in managerial decisions were important to 91% of respondents, but dissatisfaction was equally high at 70%. This was interesting and might reflect an aspect of the organisational culture of HEIs, which nurse lecturers do not 'enjoy'.

Opportunities for networking were also explored. Eighty two percent felt it was important to network but there were mixed feelings of satisfaction about this aspect of the role as approximately half the respondents expressed that they were satisfied (33%) with this aspect of role whilst half were not (38%). This could indicate disparity with this role attribute where some nurse lecturers are given opportunities to network and others are not.

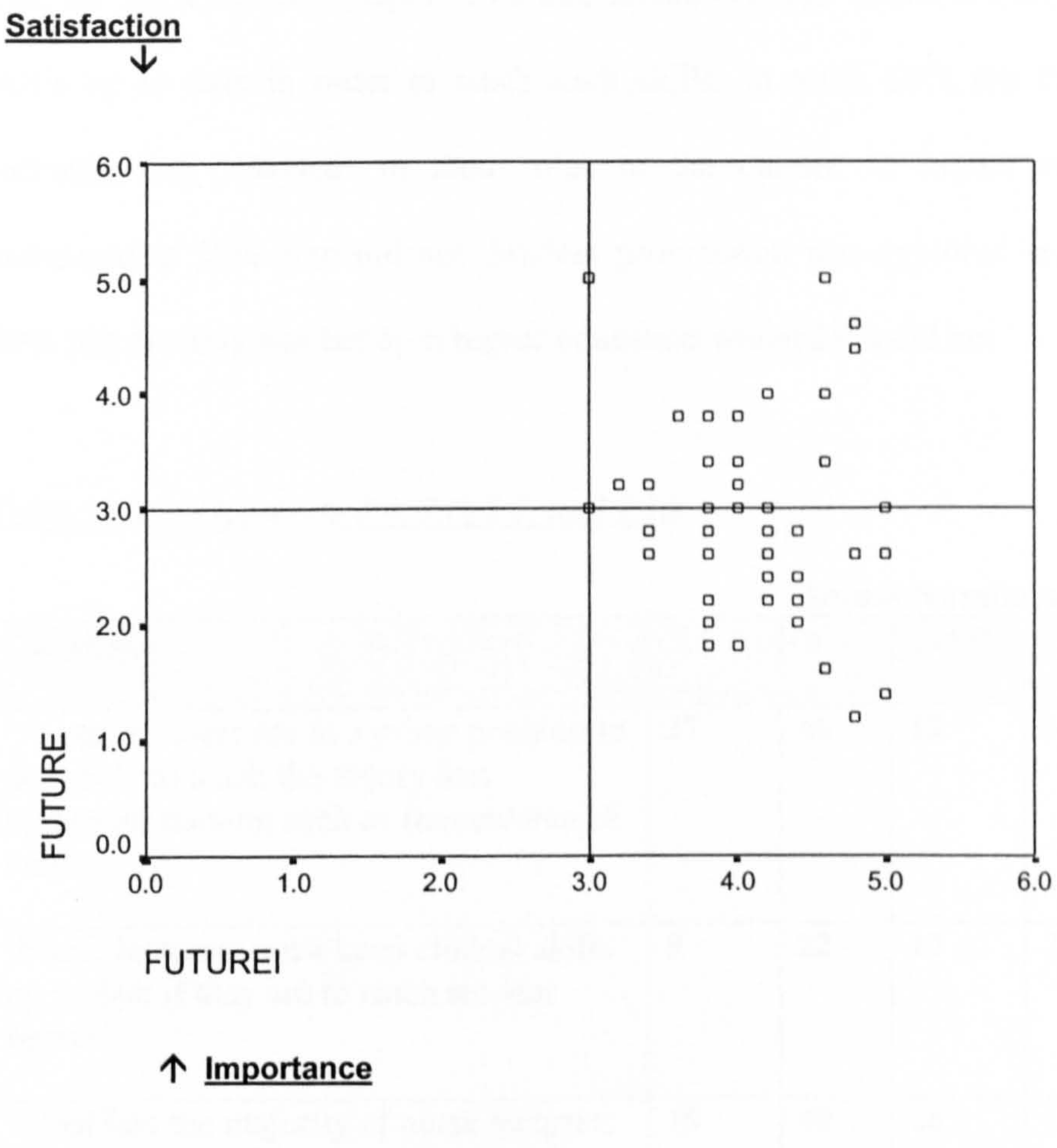
Table 10.21 below represents the mean, range and minimum scores of future role attributes. No data was missing from the questionnaire in this group (n=98). The mean importance was high at four, whilst satisfaction was lower (2.8).

Figure 10.6 represents the cluster of responses for this group diagrammatically.

Table 10.21. Mean and range scores of future role attributes

		Satisfaction	Importance
6. Future role attributes	**Valid**	98	98
	Missing	0	0
	Mean	2.8918	4.1531
	Range	3.80	2.00
	Minimum	1.20	3.00
	Maximum	5.00	5.00

Figure 10.6. Satisfaction/importance of future role attributes



10.4.6. Cultural understanding of higher education

Notions and beliefs about cultural understanding of the nurse lecturers' role with respect to teaching of theory and practice were explored in questions 7.4; 7.6; 7.7 and 7.10 (Appendix 10b).

As outlined in Table 10.22, respondents felt that nurse lecturers were in a prime position to teach the theory that underpins nursing. However, it was also found that the nurse lecturer respondents had mixed feelings about keeping clinical skills up to date in order to teach such skills. In total, 56% felt that nurse lecturers had 'adapted' in their roles to the culture of higher education, compared to 17% who did not. Student progression was explored and largely 50% felt that this was better in higher education whilst 28% did not

Table 10.22. Questions 7.4, 7.6, 7.7. and 7.10

	Actual Numbers (n= 98)				
Question	***SA***	***A***	***NA/D***	***D***	***SD***
'Nurse lecturers are in a prime position in their role to teach the theory that underpins nursing such as frameworks of care'	**37**	**46**	**12**	**3**	**1**
'Nurse lecturers must keep clinical skills up to date if they are to teach student nurses'	**9**	**22**	**17**	**28**	**22**
'I feel that the majority of nurse lecturers have had difficulty in adapting to the culture of Higher Education'	**15**	**40**	**26**	**15**	**2**
'I feel that student progression is better in higher education'	**8**	**41**	**21**	**21**	**7**

10.4.7. Personal information about higher education

The extent to which nurse lecturers understood the culture of higher education was explored in questions 7.2; 7.3; 7.5 and 7.9 (Appendix 10b).

Views were mixed about whether working in higher education gave nurse lecturers more status than in their previous 'nurse teacher' role in the National Health Service (Table 10.23). The results demonstrated that overall 50% disagreed with the statement and so believed that they had more status as a university lecturer, whilst 33% agreed and therefore felt that previous 'nurse teacher' work in the NHS had more role status.

Whilst only 23% overall felt that they made many contacts since the merger into higher education 55% felt that they had not. Work isolation was felt to be less in 14% of the respondents, but 79% felt that this was higher in higher education. There was little disagreement about personality and motivation helping to adapt to the nurse lecturers' role in higher education as overall 94% agreed with the statement.

Table 10.23. Questions 7.2, 7.3; 7.5 and 7.9.

Question	Actual Numbers (n= 98) SA	A	NA/D	D	SD
'Working in Higher Education does not give me more status than previous nurse teacher work in the National Health Service'	17	16	16	36	13
'I have made many local and national new contacts since the merger into Higher Education'	9	14	21	35	19
'I feel that the work isolation is less since the merger into higher education'	1	13	7	35	42
'I feel that I have adapted to higher education because of my own personality'	64	28	5	1	0

10.4.8. Organisational Higher Education Information

Organisational higher education information was explored in questions 7.1 and 7.8 (Appendix 10b). Findings are illustrated in Table 10.24.

Question 7.1 related to promotion prospects and status of lecturers in higher education. In total 76% felt that promotion was limited and only 12% disagreed with the statement. Pressures of the nurse lecturer role in higher education were explored in question 7.8. Results highlighted that 81% felt that role pressures were greater in HEIs and only 5% felt that this was not the case.

Table 10.24. Questions 7.1 and 7.8.

	Actual Numbers (n= 98)				
Question	***SA***	***A***	***NA/D***	***D***	***SD***
'In the Higher Education system my chances of promotion are limited'	**42**	**32**	**12**	**10**	**2**
'I feel that the pressures of undertaking the nurse lecturer role are greater in higher education that in the college of nursing'	**48**	**31**	**14**	**5**	**0**

10.4.9. Benefits of role in higher education

All respondents were asked to identify one benefit and one problem of the nurse lecturer role in higher education and qualitative findings are represented in Table 10.25. The main benefits of the nurse lecturer role in higher education was cited as the increased theoretical /professional base this would bring to the profession of nursing (55/98). Other cited issues included the flexibility and autonomy of the nurse lecturer role (21/98) and improved modular delivery of courses (20/98).

Table 10. 25. Perceived benefits of role in higher education

Perceived benefits of role in higher education	**Actual numbers (n = 98)**
Increased theoretical / professional base of nursing (such as personal development, academic credibility, research base)	**55**
Flexibility of role/ autonomy/ terms of contract Creativity of role attributes	**21**
Course/modular delivery	**20**
Teaching delivery and student relationships	**4**

10.4.10. Problems of role in higher education

The main problems of working in higher education for the sample was the increased role demands and pressures (37/98), loss or decreased clinical work (21/98), teaching large groups (12/98) and lack of support (10/98) (Table 10.26). Although a small number, eight felt that isolation was a problem both in terms of geographical and personal sharing with other nurse lecturers.

Table 10.26. Perceived problems in higher education

Perceived problems of role in higher education	**Actual Numbers (n = 98)**
Increased role demands and pressures versus time (stress, development of new roles & challenges) Quantity of administration work	**37**
Loss of and/or decreased clinical work, clinical credibility and expertise (keeping up to date, Theory /practice gap)	**21**
Teaching large groups (Quality versus quantity) (difficult or poor relationships re: student development)	**12**
Lack of support (retention and recruitment policies)	**10**
Isolation (Geographical and professional sharing)	**8**
Loss of nursing specialisation	**3**
Academic / research pressures	**3**
New rules and system	**2**
Poor communication pathways (unclear roles)	**2**

10.5. Summary of questionnaire findings

In summary, the questionnaire at Stage 4 used a mixed qualitative and quantitative design and meant that nurse lecturers in two other institutions could be reached. In terms of research technique, it was found to have great potential in evaluating respondents' views. Overall, the quantitative results were useful in supporting the data generated by Stages 2 and 3. A large proportion of the nurse lecturers had settled into employment conditions, which in turn affects role performance. There were, however, many 'grey' areas. One example was that, whilst the nurse lecturers knew what their new titles were in HEIs, there existed some personal perceptions about acceptance of these titles.

These quantitative findings also indicated that a high proportion of the nurse lecturer respondents were in the age group of 31 – 50 years and the largest group had been employed from 7 to 15 years. Given that nurse lecturers are traditionally very experienced nurses on entering a career in education this would seem to be of concern for retirement issues as a large proportion of existing nurse lecturers will leave education together (in approximately 15 to 25 years).

It was of interest to record that a very high proportion of respondents cited that they entered a career in education because they 'enjoyed teaching' and felt that nurse lecturers were in a prime position to teach the theory that underpins nursing. However, clinical issues resulted in the most significant results and appeared to be the most problematic aspect of the role for the nurse lecturers.

Role autonomy and communication with senior staff and colleagues raised issues of disparity within the role of the nurse lecturer. The satisfaction/ importance scales were useful in highlighting that whilst some nurse lecturers appeared satisfied with the model, others were not. The findings indicated that the aspects of role that nurse lecturers felt were important and were satisfied with included classroom, student and personal attributes. Conversely, respondents indicated that clinical and managerial/administration aspects of the nurse lecturer role were important but in these areas they were least satisfied. Future role attributes findings also indicated that whilst aspects were felt important satisfaction was variable, specifically noted in research, publishing and networking activities.

The qualitative findings highlighted similar disparity. Nurse lecturers appeared to 'enjoy' the academic development and flexibility of the role. Largely, they felt student progression was also 'better' in higher education. Issues of concern were that they felt that geographical and professional isolation was high and that the culture of higher education resulted in increased role demands. Interestingly, it was also found that the nurse lecturer respondents had mixed feelings about keeping clinical skills up to date in order to teach such skills. Such issues would seem to relate to the fundamental issue of role clarity and in the study reported highlights possible issues of equity in higher education. There are a number of possible considerations for this, which will be discussed further in Chapter 11.

Chapter 11

Discussion and recommendations

11.1. Introduction

There are a limited number of studies that have examined how roles evolved from 'Nurse Tutors' in colleges of nursing in the NHS to 'Nurse Lecturers' in HEIs. This study was one attempt to address this. In the study reported, different perspectives were identified at strategic points in the merger process and changes in the nurse lecturer role attributes were traced. One contentious issue identified early in this study (Chapter 1; Section 1.1.2) related to the title of the group being studied and therefore a decision was made to use the title of nurse teacher throughout the bulk of the work. However, nurse teachers are now fully integrated into HEIs, and are known as 'Nurse Lecturers', and so it was decided contextually that this current title would be best used in the final three chapters, including this final chapter. This chapter will discuss the overall findings from each stage of the study and consider limitations in the methodology discussed. The aims are included here to serve as a reminder:

(i) Explore perceptions of the nurse teachers' role as they move from working as nurse teachers in colleges of nursing in the National Health Service (NHS) to working as 'Nurse Lecturers' in higher education institutions.

(ii) Explore the impact on the role attributes of nurse lecturers as they develop their new roles in higher education from both an individual (micro) level and the wider organisational culture (macro) level.

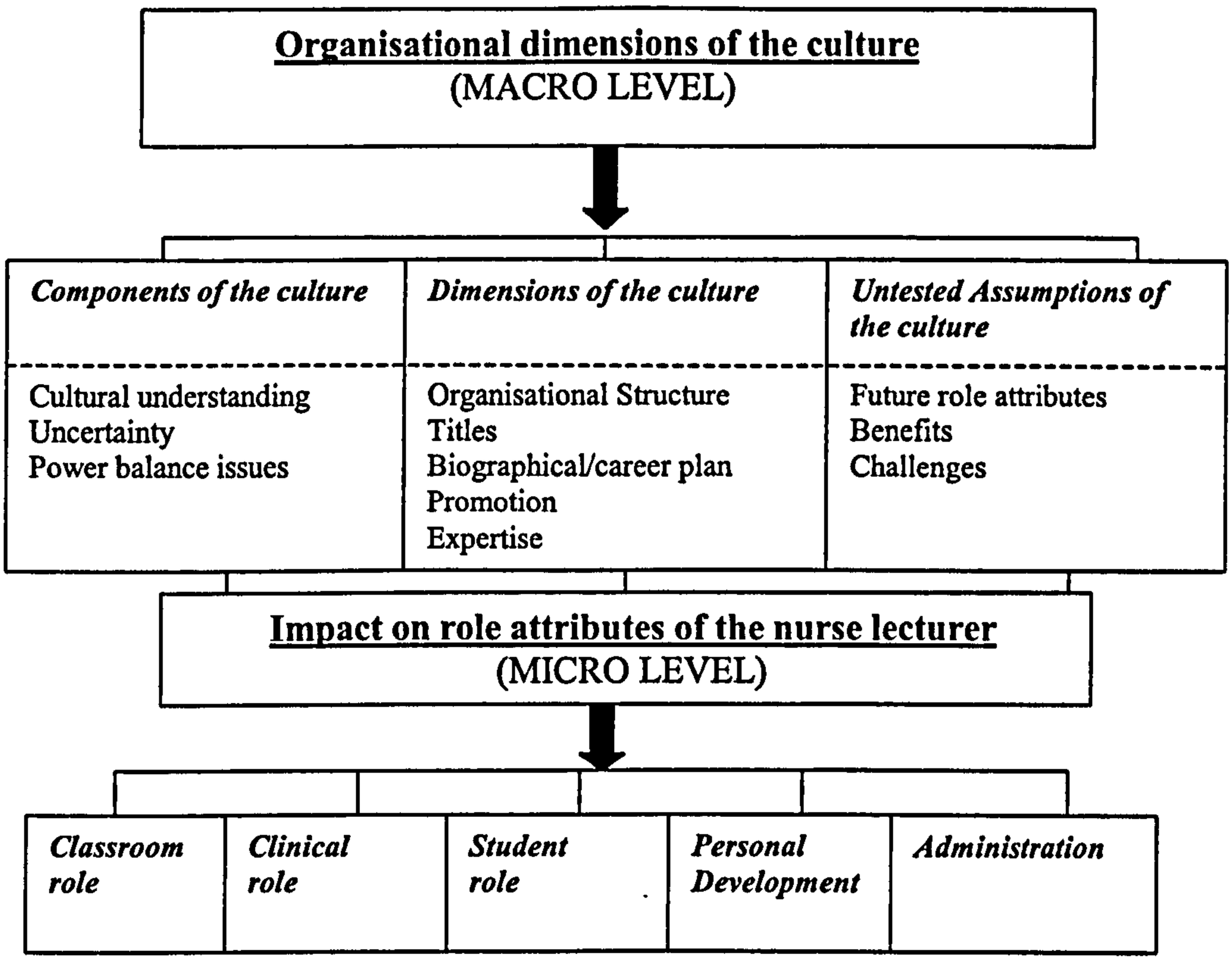
(iii) Explore the perceptions of clinical nurses in relation to the nurse lecturers' role as a result of nurse education transferring into higher education.

(iv) Make recommendations about the nurse lecturer role that may be used to understand the role more clearly.

Emerging literature had been previously used to develop a theoretical framework (Chapter 5; Section 5.6). Whilst this had produced a starting point for the study, it was noted that some of the emerging findings specifically at the longitudinal stage of Stage 2 (Chapter 8; Section 8.7) conceptually differed to the literature. The reasons for this may reflect the different organisational culture and role expectations within in HEIs, which will be expanded in this chapter (Section 11.2.2.1). Alternatively, it may reflect the way in which the study evolved in using the cited organisational cultural literature to underpin the context of this study. Moreover, this model has not been used previously in nurse teacher work.

Thus, emerging findings from this study have been used to develop a further theoretical framework (Figure 11.1), which will be used to frame the discussion in this chapter. Recommendations for the future role of nurse lecturers are included at the end of the study.

Figure 11.1. Theoretical framework for discussion



11.2. Organisational dimensions of the culture (Macro Level)

Using the framework in Table 11.1 perceptions of the nurse lecturer role in higher education are discussed from a cultural perspective.

11.2.1. Components of the culture

It was noted (Chapter 5; Section 5.4.1) that components of the culture, include the existing norms, beliefs and underpinning philosophy that constitutes the set of norms for any organisation (Sackmann 1991). The components of the culture, which emerged out of the findings of this study, at all stages, are listed in Table 11.1 as areas for discussion.

Table 11.1.
Components of the culture (prior to the merger and after the merger)

Prior to the merger ↓	*After the merger* ↓
Cultural Understanding	
Clear philosophy of college but a lack of understanding about higher education culture. Lack of preparation = high anxiety	Unclear philosophy although developed understanding about higher education culture.
Uncertainty	
Certainty/familiarity in nursing college Security Role conflicts	Uncertainty avoidance in higher education Insecurity Role conflicts (new and old)
Power balance	
Less autonomy /more collective Hierarchical /Promotion based-model	Greater autonomy/ more isolation Flattened hierarchy

11.2.1.1. Cultural Understanding

One aspect of the underpinning philosophy of any organisation is the understanding of what this means to staff. In the study reported, the indications were that integrating two organisational cultures, that of the NHS culture in the nursing college with higher education culture was difficult for the nurse lecturers. This related to issues pertaining to understanding. For example, at Stage 2a, prior to the merger, findings indicated that, whilst there was clear understanding of College A, there was a lack of cultural understanding about University A and higher education culture. At this stage, the nurse lecturers were found to be ill prepared for the 'merger event', which was to take place three months following the interviews. At a personal level, a majority of nurse lecturers admitted they had had only 'grapevine' discussion with colleagues. In terms of role, they felt safe in the culture of College A and appeared 'secure' in

their roles. In short, they knew what was expected of them and how to perform it. Arguably at that time, the merger was not seen as a real event, but it is that lack of preparation, which could have added to later anxiety and role conflict (Sackmann 1991).

At an organisational level, a lack of preparation was also recorded. For example, at Stage 2a, whilst College A had begun to prepare staff for the forthcoming merger, University A did not initially inform nurse lecturers about the future. As recorded, many stated that they did not understand how the systems of University A worked and arguably, did not know how to find out. This lack of information about the new organisation appeared to heighten anxiety and more specifically, helped develop misinformation. This was an important oversight as none of the nurse lecturers in this study had experienced working in a HEI before. As highlighted (Chapter 5; Section 5.3), Mabey and Mayon-White (1993 pp92) note that in reducing information errors, one important action step is 'participation', where communication and sharing of information is facilitated in order to develop 'ownership' of the change occurring. As communication and sharing of information appeared limited in the study reported, a sense of powerlessness was evident at both Stages 2a and 2b. It was, therefore, indicated that at these stages of the study reported, the merger was not met as a positive challenge, but rather was viewed as a threat.

As outlined (Chapter 5; Section 5.4.1), Allan & Jolley (1987) suggest that as a result of a lack understanding of higher education, an anti-academic culture could develop. Answers pertaining to this aspect were noted in many of the

transcripts at Stages 1, 2a, 2b and 2c of the study reported. Findings also emerged at Stages 2 and 3 from both the nurse lecturers and clinical staff that the merger into HEIs was felt to be essential for the development of nursing as a profession. However, it was also felt that nursing skills and care would be affected. Therefore, a strong traditional perspective ('this is the way we have always performed nursing') was evident and was in direct conflict with an academic perspective ('using research and evidence to suggest ways of doing nursing').

11.2.1.2. Uncertainty

A further component of the study findings, related to uncertainty. Findings at Stage 2a indicated that nurse lecturers were settled and felt secure in the role. At Stages 2a, 2b and 2c, it appeared that the merger into HEIs had generated a great deal of uncertainty and consequently anxiety. The findings of this study support other studies that also highlighted that there was a great deal of uncertainty about what the role expectations of nurse lecturers in HEIs were (Luker et al 1993, 1996, Carlisle et al 1996, 1997, Barton 1998, Evers 2001). But what was notable in this study was that in some accounts participants admitted to uncertainty avoidance, where the members of an organisation feel threatened by uncertain situations or the unknown occurring and so simply avoid it (Hofstede 1991, 1994). In terms of nurse lecturers in this study, this could have had an immense impact on their role. For example, at Stages 2b and 2c, some nurse lecturers appeared to have accepted, even embraced the higher education culture of University A, whilst others remained resistant. Arguably, if the nurse lecturers were not receptive to the merger into higher education, then

uncertainty avoidance and inevitable resistance appeared higher. Alternatively, although the sample is small and cannot be generalised, those nurse lecturers who were more receptive to the merger did appear to settle far quicker.

Such findings beg the questions: were the lecturers in nursing ready for their roles in higher education and was higher education ready for the nurse lecturer? The uncertainty about the role of nurse lecturers in HEIs, which emerged from the findings of this study, would seem to indicate that the transition was problematic for many of the nurse lecturers. Clearly, such evidence has implications for future planning of the role of lecturers of nursing.

11.2.1.3. Power balance issues

A further component recorded in this study was the changes noted in the balance of 'power' and 'leadership' in College A and University A. As outlined previously (Chapter 5; Section 5.3), Hofstede (1991) refers to the distribution of power between 'bosses and subordinates' as the 'power distance'. It was notable in the findings of this study, that at Stage 2a and 2b, the managerial structure of College A comprised of clear positions and that the nurse lecturers expected to be told what to do. At Stage 2c in University A, it was then notable that management hierarchies were perceived as more flattened and that there was more equality and greater consultation across all levels. At Stage 4, management structure responses indicated that some nurse lecturers were satisfied with the model, whilst others were not. Therefore, both qualitative and quantitative findings in this study appear to indicate that some nurse lecturers

prefer this style of management whereas others did not, which would seem to relate to the previous discussion points about acceptance.

Issues of leadership also arose in answers pertaining to promotion. At Stages 1, 2a and 3 of this study, findings supported the notion that nurse lecturers worked within a model of hierarchical management in College A. At Stage 2c, findings indicated that the nurse lecturers at this stage felt that promotion in higher education was limited. At Stage 4, communication with senior managers was viewed as important to respondents, but satisfaction was mixed between those highly satisfied and those highly dissatisfied. These are interesting findings and echo previous points about some 'nurse teachers' having embraced the higher education model whereas some others have not.

Such findings were not observed in any of the literature, but could be related to the organisational culture within the NHS (Chapter 2). Given that a high proportion of nurse lecturers were well developed 'Ward and/or Clinical Managers' on entering nurse education and were familiar with the hierarchical culture of the NHS, the model of higher education might result in frustration and dissatisfaction about these aspects. Another issue highlighted by Barton (1998) and Day et al (1998) (Chapter 3), was that redundancies of nurse lecturers were high prior to and at the merger into higher education. In the college of nursing senior managerial posts were a dimension of the culture, this raises specific considerations that nurse lecturers may feel that there are less opportunities for such promotion and/or there may be a perception that there are less senior staff to seek support from. At the same time, as student numbers

continue to rise, recruitment for 'new' nurse lecturer posts may not be meeting the educational demand for student support. As a consequence this may add to increased responsibilities and potential stress. Whilst this study did not explore work related stress in depth, further research into such issues would seem warranted.

A further example of power balance issues in this study related to the conditions of employment such as job contract, office space, flexibility and autonomy. Such employment issues emerged out of the findings at Stage 2c, when terms and conditions of work were felt to be problematic, in that the reality was far from what nurse lecturers had envisaged at Stages 2a and 2b. These findings were supported by Evers (2001) work (Chapter 3). However, at Stage 4 a large proportion of the nurse lecturers in University B and C appeared to have settled into the employment conditions stating generally high satisfaction for the issues of job contract, office space and work flexibility. Arguably, this may have been the differing university culture from University A, timing of the distribution of the questionnaire or indeed a questionnaire design issue, but overall satisfaction in these aspects of the role was generally high. Indeed, a large number of respondents at Stage 4 also stated that they were very satisfied with their status as a university lecturer in a HEI indicating that overall the nurse lecturer respondents in this study had settled into conditions of employment in higher education.

The findings at Stage 2, however, appeared to indicate that some nurse lecturers had more role autonomy than others, and issues relating to equity and disparity

of workload in higher education did arise in the interviews. This was most noticeable at Stage 2c, which highlighted that those with limited autonomy felt more isolated from colleagues. Hofstede (1991) notes that where employees work in an individualistic organisation (such as higher education) they are expected to act according to their own interest, whereas in a collectivist system (as in the nursing college) people are integrated into strong, cohesive groups (Chapter 5). The problem with such cultures is that, if individuals are satisfied with one culture, accepting and evolving a role in a different one could be a difficult challenge as indicated in the findings of this study.

11.2.2. Dimensions of the culture

Sackmann (1991) and Mabey & Mayon White (1993) suggest that the dimensions of culture are influenced by the boundaries (Chapter 5; Section 5.4.2), which include examples such as the expertise of the staff and organisational rules and structure. These were found to be useful background material in the study reported, as 'boundaries' found in this study included organisational structure, expertise, career plans and titles and are listed in Table 11.2 as areas for discussion.

Table 11.2.
Dimensions of the culture (prior to the merger and after the merger)

Prior to the merger ↓	*After the merger* ↓
Organisational Structure	
Clear rules and structures Clear communication Nursing curricular developments Well-delineated posts	Unclear rules and structures Less clear communication Modular curricular developments Well-delineated posts
Titles	
Clear titles of Nurse Tutor	Unclear at merger point Lack of clarity in use
Biographical/career plan	
Clear career plans Required academic development	Less clear career plans Increased academic development
Expertise	
Teaching Clinical role	Teaching Clinical role

11.2.2.1. Organisational Structures

It emerged from the findings of the study, that the nursing college workforce was organised within clearly defined organisational structures with clear rules, which appeared quite 'formal'. At Stage 2a, the bulk of participants understood the formal and informal rules of the college of nursing, which subsequently acted as a safety net for employees. Interestingly, at Stages 1 and 2a, whilst a very small minority did not 'enjoy' these aspects of the culture stating that they found the nursing college 'rules' to be restrictive, the majority of nurse lecturers did.

Such observations were also recorded in the previous findings of Luker et al (1993) and Clifford (1995a). However, what was a new finding in this study was the nurse lecturers' adaptation to the new organisational structures of higher education and associated anxiety responses. Whilst the culture of higher education was expected to be different, at Stage 1 nurse lecturers had stated that they were not anxious about the merger into higher education. At Stage 2a, nurse lecturers had expected the culture of University A to be 'different' and as the merger was more imminent some anxiety was recorded. At Stage 2b the emerging data indicated that the group were beginning to 'feel' a change in the organisational culture, being precipitated by the additional information received from College A and University A, again anxiety was high. At Stage 2c it was interesting to record that anxiety had reduced. There are some considerations on these points in that at Stage 2b, it may be argued that the nurse lecturers had not totally felt the impact of the 'merger event' and that the role at this stage had not significantly changed. Consequently, at this stage, the culture was largely still unknown to them. This may in part have been due to the lack of cultural awareness about higher education and their expected role. This raises the question whether such findings had an impact on their role perception and subsequent performance following the merger into higher education.

As noted in this chapter, the findings of this study differed to the theoretical framework that had emerged from the literature. Specifically, this related to the role of curriculum development. Research undertaken prior to the merger had indicated that one role expectation of the nurse lecturer had been curriculum development, an aspect they clearly understood in the nursing colleges (Clifford

1995a). This study found that, whilst curricular development emerged in the findings at Stages 1, 2a and 2b, as part of the nurse lecturer role, this changed at Stage 2c, cited not as part of their role, but rather as a part of the overall university educational culture such as wider choice and modular delivery. There may be several reasons for this. It may be that, as the nurse lecturers in this study were finding their places in University A, they were unsure about what was expected of them. Some transcripts referred to the multiple stakeholders, wider choice and increasing student numbers, which added to the confusion of what was expected in terms of curriculum development. The clinical staff at Stage 3 reiterated this point in that overall they were not aware about the courses and the content being delivered in University A, or even the educational strategy, which was a concern. It may also have been that at the time there appeared to be little development of the pre-registration nursing curriculum as indicated in the findings of the UKCC (1999) report. What is most worrying about these findings is that if curriculum development was not viewed as an aspect of the nurse lecturers' role, then one question left outstanding is whose responsibility is it?

11.2.2.2. Title of the nurse teachers

One important dimension was noted in the delineation of the staff or more specifically, what the nurse lecturers used as their job titles. Most specifically, although at Stage 2c nurse lecturers had 'settled' with respect to their titles, considerable confusion was noted at Stage 2b. Furthermore, findings indicated that whilst there was acceptance of the 'lecturer' title at an organisational level some personal issues remained and therefore need discussion. Confusion about

the titles of 'nurse teacher', 'nurse tutor' and 'nurse lecturer' is not uncommon, as demonstrated in the concept analysis (Chapter 4), but the findings of this study showed how the nurse lecturers responded to this. For example, at Stage 2a, participants had well-established titles of 'nurse tutor'. At this stage, the participants were aware of the expected change in title as they moved from College A into University A, but were unclear what the new titles would be. This was to have severe implications. As indicated, at Stage 2b there appeared to be much confusion over the nurse lecturers' title. At this stage, the majority of the nurse lecturers were 'Senior Lecturers', but only a handful referred to this, whilst most participants identified with 'nurse tutor' and some were even unsure.

Some lack of title clarity appeared to relate to the point that the nurse lecturers in this study did not have their job contracts at the merger point and this may have contributed to their increased uncertainty, anxiety and stress levels due to needing to prove themselves. However, some of this may also have been because the title of 'nurse tutor' was the traditional and therefore the recognised, expected title. Certainly, at Stage 3, clinical staff felt that nurse lecturers were still called 'nurse tutors' and it was suggested that even 'new' students referred to them by this title. This may be indicative of what clinical staff believed they were still called, but could reflect a lack of acceptance and/or understanding of the new roles in higher education. However, in retaining the use of this title it could be suggested that nurse lecturers were, therefore, colluding with such hidden expectations. Indeed, they were perpetuating the title even at Stages 2c, over a year after the merger into higher education.

The evidence for this finding was also recorded at Stage 4 of the study reported. The quantitative findings of Stage 4 indicated that, whilst nurse lecturers knew what their new titles in HEIs were (i.e. largely that of Senior lecturer), personal perceptions and acceptance of these titles was less clear. This was most specifically noted in questions pertaining to use of titles on a day-to-day basis on the telephone. Interestingly, sixteen respondents at Stage 4 still felt that they were nurse tutors and used this title on the telephone (Chapter 10, Section 10.4.3). This has implications in that if new titles are not readily used, arguably this may reflect a wider lack of acceptance about the new organisation.

11.2.2.3. Biographical /career pattern of nurse teachers

A further dimension of the culture was noted in the biographical data and career structures of the nurse lecturers. As outlined elsewhere (Section 7.2.1), at Stage 2a, participants felt that they had considerable experience in the clinical field, were in senior posts and chose to enter nurse education for a variety of reasons most commonly self-development and an interest in education delivery.

Overall, the qualitative findings at Stage 2 and the quantitative findings of Stage 4, highlighted that nurse lecturers had entered nurse education for a variety of reasons, most commonly that they enjoyed teaching, to be a positive role model, academic self-development and that they were advised by other nurse teachers. They were also in the age group of 31 to > 51 years and the largest group had been employed from seven to 15 years. This would seem to be of concern for retirement issues as large proportions of existing nurse lecturers will potentially

retire from their careers in nurse education over a time span of the next ten to 30 years. Whilst interesting this was not the focus of the study reported. However, if 'new' nurse lecturers are not recruited to compensate for this fall out, then this raises issues as to who will teach the next generation of nurses and how will they be attracted into an academic, higher education career.

This study also found that nurse lecturers had developed academically since the merger into higher education. For example, at Stage 2a, whilst the nurse lecturers possessed relevant teaching qualifications, it was most notable at Stages 2b and 2c that an increasing number had obtained or had enrolled for higher academic qualifications. This was also found at Stage 4, where not only a range of professional and teaching qualifications were noted, but also a number of respondents had (or were registered) for higher academic qualifications. Such recorded change may demonstrate that nurse lecturers had adapted to new expectations of working in higher education and had seized academic developmental opportunities. But this does raise the question that whilst nurse lecturers are developing their academic profiles who is doing the teaching and other expected activities, and more importantly what then gets dropped (Clifford 1999, Coad 1994).

11.2.2.4. Expertise

One notable expertise issue that arose in this study was teaching role, one example of this being the expected 'level' of teaching. Prior to nurse education entering into HEIs the levels of attainment were largely up to diploma (level 2) both in pre and post registration courses. At Stages 2a and 2b, all the

participants interviewed taught up to diploma level. In HEIs expected delivery encompasses diploma (level 2), degree (level 3) and masters (level 4) levels. Indeed, it was noted that, at Stage 2c, whilst the level of teaching of some of the nurse lecturers had altered up to degree level 3 teaching, the bulk of the nurse lecturers interviewed still taught largely on diploma programmes.

At the same time, however, all the participants identified at Stages 2a, 2b and 2c, that they needed to increase their 'specialist' focused teaching, as part of an expectation that they would deliver a wider range of programmes. These findings are not unique and were also identified by Luker et al (1993, 1996) and Carlisle (1996, 1997). Although in one sense this is useful to development, there is a danger that this appeared to add to nurse lecturers' anxiety. However, the previous model of teaching had been a 'Jack of all Trades', which was highlighted in the review to be equally problematic (Clifford 1995a). Clearly the consequences of teaching as a lecturer of nursing in a HEI are still to be fully realised and present a difficult dilemma, one which future nursing educational planners need to consider seriously.

A further finding was that, at Stage 2a, nursing expertise had been cited by all fifteen participants to be a current role attribute, but only four felt that this would be required in the future role in higher education. Therefore, a perceived future problem at Stage 2 was the loss of clinical skills and increased theory/practice gap. This discussion will be expanded in following section.

11.2.3. Untested Assumptions of the culture

It was noted that untested assumptions are based on managerial or personal assumptions about the organisation and are frequently unclear beliefs about the future of the organisation or personnel (Sackmann 1991 pp111). One untested assumption recorded in this study was the nurse lecturers' perceptions about their future role in higher education culture. This included issues relating to perceived benefits and challenges of performing the role (Table 11.3) These are discussed further.

Table 11.3.
Untested assumptions of the culture (prior to the merger and after the merger)

Prior to the merger ↓ *After the merger* ↓

Benefits/ Challenges of higher education	
Academic development Development of nurses Increased professional base of nursing	Increased academic and research development Increased theory/practice gap Development of nurses Increased professional base of nursing

11.2.3.1. Perceived benefits and challenges

During the longitudinal stage of the study reported, it appeared that some nurse lecturers were more aware and accepting of higher education culture, whilst others preferred to carry out the role as they had in the nursing college. This related strongly to the notion of perceived benefits and challenges of the nurse lecturer role in higher education. Specific findings that exemplified these prepositions included academic and research development.

Academic development was perceived as a future role benefit of working in higher education at all the stages of the study. Specifically notable at Stage 4 was that the nurse lecturers of University B and C, not only felt that academic development was important, a large proportion were satisfied with this aspect. Those nurse lecturers who were dissatisfied appeared to be over 50 years old. There may be several suppositions for this finding. Firstly, it may indicate that those over 50 years old may be more experienced and have larger organisational workloads or commitments. Consequently, opportunities for personal academic development were seen as a challenge as their role responsibilities appeared to outweigh these issues. However, it may also be that in working within the culture of the NHS for longer where academic development was not a role expectation, this group did not feel that they wanted to develop in this way. Equally, as the group is nearer to retirement they may have decided that they do not feel that they want to embark on further study at this stage in their careers.

A further consequence of the move into higher education is the expectation that nurse lecturers would undertake research and publishing activities (Clifford 1999, Clifford et al 2001). For 'nurse tutors' working in the colleges of nursing, research and publication was not a major component of their work but in HEIs such activities are valued, as the generation of new knowledge is a critical part of academic activity. However, at Stages 2a, 2b and 2c in this study, it was found that the need to publish and undertake research activities were seen as a concern as it was felt that this would increase 'work pressures' and associated stress. Respondents at Stage 4 in University B and C, demonstrated mixed

views about their 'research development' and 'publication profiles', where some were satisfied and others were not.

There may be contrasting reasons for such findings. Using the findings from Stage 4 such findings are represented in Table 11.4. Firstly, reasons for nurse lecturers not being satisfied may include situations where a lecturer wants to undertake research and publishing activities but they are unable due to a lack of opportunities, increased role conflicts or not supported within the university where they were employed. This would be the case for those nurse lecturers registered for higher degrees, for example, where they felt that they needed more research and publication activities, but were unable to get such opportunities. Alternatively, nurse lecturers may feel dissatisfied in situations where they were encouraged to research and publish (due to the university values), but in reality the nurse lecturer did not want to or did not feel able to undertake such activities.

Those nurse lecturers who were satisfied with research and publishing activities can also be analysed (Table 11.4). If a nurse lecturer felt that they wanted to undertake research and publication activities and they were given support for such activities, then it would follow that they would respond as satisfied with this aspect of the role. However, if a nurse lecturer did not want to undertake such activities and were not specifically encouraged to do so, then they also would be satisfied but for different reasons. These are clearly unanswered suppositions but interesting given the higher education culture related to such role expectations.

Table 11.4. Research /publishing role of nurse lecturers (findings from Stage 4)

Low satisfaction **Low Importance** Nurse lecturer does not want to undertake research /publishing activities Can not due to role conflict Supported to undertake activities (contract/university values) **Unhappy =** **↑Dissatisfaction**	**Low satisfaction** **High importance** Nurse lecturer wants to undertake research/ publishing activities But can not/not able due to lack of opportunities/ not supported (contrast /university values) and increasing role conflicts **Unhappy =** **↑Dissatisfaction**
High satisfaction **High importance** Nurse lecturer wants to undertake research / publishing activities Undertaking research/publishing activities Given opportunities Supported (contract/university values) **Happy =** **↑Satisfaction**	**High satisfaction** **Low importance** Nurse lecturer does not want to undertake research/publishing activities Do not research/publish Not supported/encouraged **Happy =** **↑Satisfaction**

As outlined, a perceived future problem noted at Stage 2 was the loss of clinical skills and increased theory/practice gap. Indeed, one challenge identified was that at Stages 2c and 3, many of those interviewed, stated that since the merger into higher education the theory and practice 'gap' was 'worse'. It appeared that nurse lecturers were therefore torn between the expected clinical role of 'nurse tutor' in the NHS and 'nursing lecturer' in the university. Some even appeared unsure about what the clinical role was.

Equally, clinical staff at Stage 3 also appeared to have limited understanding of what this the new role would bring with respect to clinical work. The nurse teacher was perceived as 'somewhat remote' and that links with clinical areas had become more problematic since the merger into higher education. At the same time geographical issues meant that the nurse lecturers in this study by Stage 3 were not based on the hospital sites as part of the NHS organised nursing college and indeed some delivery took place over multiple sites.

Clinical role attributes since the merger into HEIs have been demonstrated to be a source of role conflict in other key pieces of research (Barton 1998, Evers 2001, Clifford et al 2001). The impact of this aspect of the role (or potential loss) is still to be fully realised but for some nurse lecturers in this study this created a great deal of role conflict. This will also be expanded in Section 11.3.3.

On the other hand, at all the stages, one future benefit of the 'merger' into higher education was the enhancement of the development of nurses and professional base of nursing. Indeed, clinical staff at Stage 3, felt that the benefits of nursing transferring into higher education were the 'flattened' structure of the university, the increased networking opportunities, higher academic qualifications and undertaking more research/publishing activities. These currently remain untested assumptions but in order to prepare for such activities personal attributes such as being more 'autonomous', being motivated, improving communication strategies and having a positive view were felt to be required. It would therefore seem important that this is recognised and support be given to nurse lecturers to develop areas of work required in higher education.

It was highlighted in the review that that the organisational culture of an organisation will impact on the role performed. In order to meet the aims of this study, it is important to explore the specific role attributes as identified from the findings.

11.3. Impact on the role attributes of the nurse teacher (micro level)

The role of the 'nurse teacher' was noted elsewhere to be a multi-faceted role prior to the merger into higher education (Chapter 3). With respect to role it has been noted that the nurse lecturers experienced considerable 'role conflict' as a result of the merger into higher education, but in Stage 2c of the study this had settled and nurse lecturers were adapting to their new roles. If the findings of this study are to be useful for nurse lecturers in their current and future roles,

now they are fully integrated into higher education, then it is relevant to discuss what the 'common' role attributes are (what are nurse lecturers doing and why?), and aspects of satisfaction and dissatisfaction. Figure 11.1 (page 393) represents the key areas that emerged out of findings. However, in reality, the relationship of these key attributes was integrated and is represented thus in figure 11.2. Table 11.5 expands the issues further for discussion in this section.

Figure 11.2. Current role attributes of nurse lecturers and their relationship

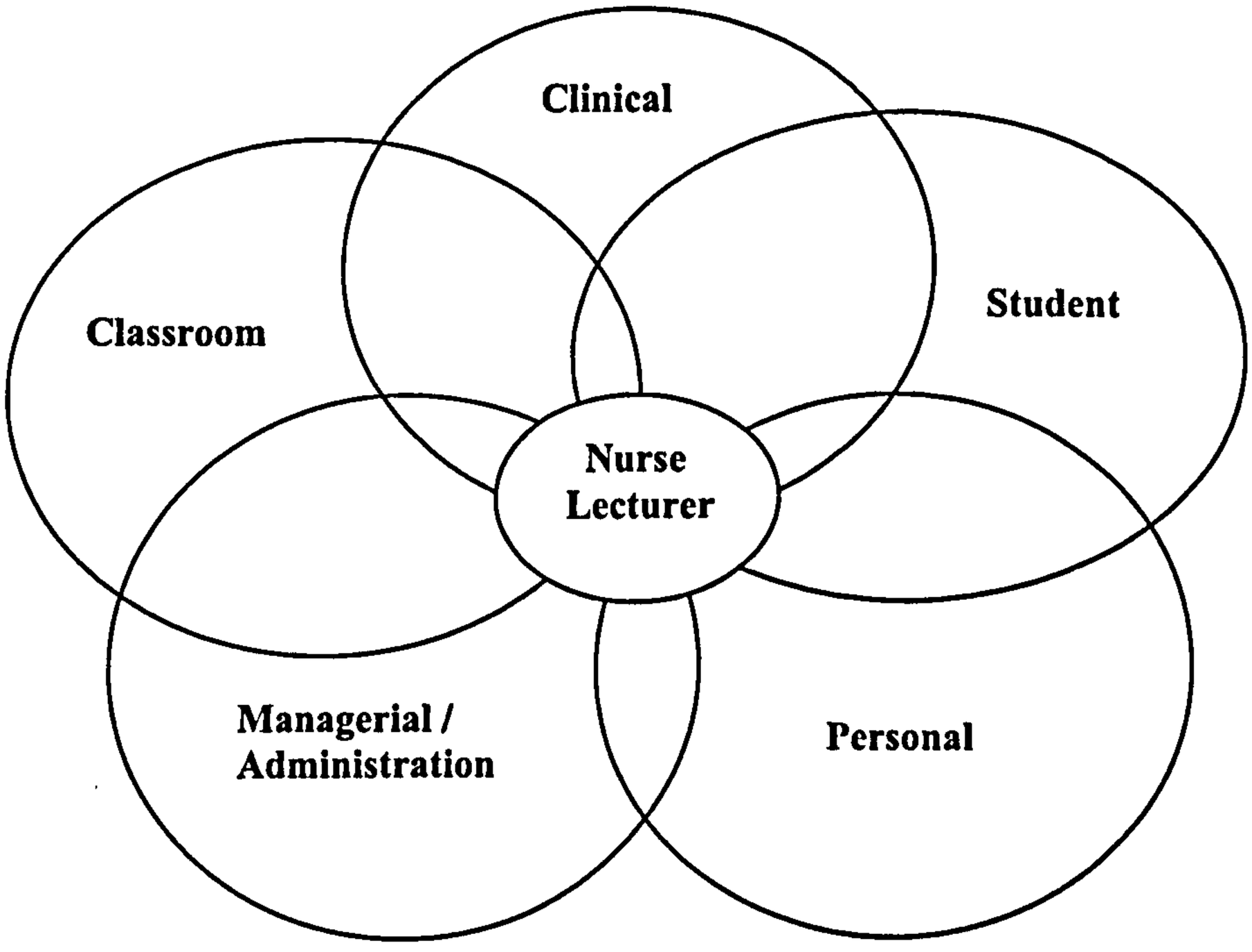


Table 11.5.
Common nurse teacher role attributes emerged from all stages of the study

CLASSROOM ROLE	
	Development of students Variety of teaching Linking theory to practice Teaching skills
STUDENT ROLE	
	Communicating with students Supporting/counselling students Development of students
CLINICAL ROLE	
	Communicating with clinical staff Nursing Expertise Linking theory to practice (Clinical) Clinical credibility
MANAGERIAL/ADMINISTRATION ROLE	
	Marking Correspondence Meetings Course Organisation
PERSONAL ROLE ATTRIBUTES	
	Academic Experience Communicating with colleagues Communicating with senior managers Positive Role Model Adaptation skills Networking Questioning skills Autonomy Motivation Hard working

11.3.1. Classroom Role

At all stages of this study, teaching in the classroom was viewed as an important attribute of the nurse lecturers' role. Key role attributes related to classroom work that emerged from the findings included the development of students, a variety of teaching including formal lectures and seminar teaching, the teaching skills of the nurse lecturers and the linking of theory to practice.

At Stage 2a, the amount of time spent in the classroom was felt to be 'about right'. It was of interest to record that at Stages 1 and 2, nurse lecturers felt that in the classroom they were in a prime position to teach the theory that underpins nursing. However, what emerged at Stages 2b and 2c which had not emerged at Stage 2a, was that there appeared to be a sense of relying on existing teaching skills in order to link nursing theory to practice. Some of this also related to teaching expertise as discussed earlier in the chapter, but at these stages it was noted that delivery of credible, up to date lectures was viewed as part of the overall adaptation to the merger.

At Stage 4, respondents indicated that whilst teaching attributes were felt to be important, there were some feelings of dissatisfaction recorded about the teaching of students in seminar groups, variety of teaching and other aspects of the teaching role, such as formal teaching. Such findings raise more questions than answers. For example, whether some nurse lecturers were satisfied because they were able to undertake seminar teaching whilst other teachers were not due to the large (and increasing numbers) of student cohorts? Alternatively, do some nurse lecturers feel dissatisfied because of the wider range of courses that they are expected to deliver? From the study reported, there is a need to explore further whether this dissatisfaction is sustained in higher education culture.

11.3.2. Student Issues

Key student role attributes included utilising communication networks, developing students and the tutorial support/counselling role that nurse lecturers' offer. At Stage 2 of the study reported, the nurse lecturers appeared to

enjoy the development of students and indeed several had cited at Stage 2a that this was the reason for entering nurse education as a career. It was indicated at Stages 1, 2 and 3 that, as a result of nurse education transferring to higher education, this was important for student nurses in relation to their professional status and more educational opportunities would be available as a consequence. However, as outlined elsewhere, most specifically at Stages 2c and 3, the large and rising numbers of students were a concern. This was specifically cited as nurse education transferring into HEIs and the expected delivery being perceived as 'different'. This finding was in keeping with the comprehensive findings of the UKCC (1999) report outlined in Section 2.6.1.

It was thus not surprising to record at Stage 2c that communication with students was viewed as even more important and that more time was needed for this aspect of the nurse teacher role. What was interesting though was that, at Stage 4, despite the rising numbers of students, a proportion of respondents were satisfied with their communication with students as a group and as individuals during tutorials. Equally, though some dissatisfaction in these role attributes was expressed and could indicate a lack of role clarity in the nurse lecturers' role in University B and C. Sackmann (1991) suggests that this is a common finding if role attributes are unclear before the merger, as some employees will adapt to the new expectations, whilst others remain unclear in their new roles and attempt to continue their previous role and become more frustrated in so doing.

The perceived pastoral/counselling role of students by nurse lecturers was also interesting, as at Stages 2a, 2b and 2c this had been cited as an important role attribute. At Stage 4, mixed responses were noted about the levels of satisfaction related to this aspect of the role. Some nurse lecturers were satisfied whereas others were not. A range of possibilities would seem feasible. For example, the nurse lecturers may have felt that counselling of students was an important role attribute and that either they did not want to undertake this themselves or that they did want to, but due to other role attributes were unable to perform this aspect of the role.

As outlined in Chapter 6 (Section 6.5) a decision was made in this study not to undertake interviews with student nurses for their perspective of the nurse lecturer role. However, further research with those who come into contact with nurse lecturers, such as students, doctors, other lecturers and allied health professionals would also seem warranted.

11.3.3. Clinical Role

Key clinical role attributes of nurse lecturers that emerged from the findings included communication with the clinical staff, personal nursing expertise, and the linking of theory to practice in the clinical setting in order to ensure clinical credibility.

At all of the stages of the study reported, the nurse lecturers' clinical role was felt to be a very important attribute, but despite this was also very problematic to achieve. Overall, the nurse lecturers lacked clarity about the nature and

purpose of their role in the HEIs studied. This is not a new finding as many of the reports analysed, before and after, the merger in higher education had mirrored such findings (Chapter 3). What was found in this study, was that, whilst the role was viewed as important by participants at Stages 1, 2a and 2b, at Stage 2c, some nurse lecturers had mixed feelings about keeping clinical skills up to date as part of their role. As this was also noted in the qualitative findings at Stage 4, it is an aspect that is worth expanding on.

One aspect was that in this study, there emerged an interesting dichotomy between what the nurse lecturers perceived the clinical role to be. For example, at Stages 2a and 2b, half of the group of nurse lecturers had an active clinical role, but for the other half the role was largely communication with staff via telephone and sporadic visits to clinical areas. Several nurse lecturers were linked to wards, which did not reflect their nursing expertise. At Stage 2c, it was noted that those that who wanted to work in clinical areas felt that the clinical role was even more problematic and so were frustrated that they did not perform this role. They claimed that this was 'worse' in higher education as the role was not valued and/or understood.

At Stage 4, clinical issues that emerged were also significant. Firstly, clinical visits to students and communication with clinical staff whilst viewed as being very important by the majority of respondents resulted in high dissatisfaction. In addition, the amount of clinical opportunities nurse lecturers were given, alongside time given for this aspect of the role, resulted in high dissatisfaction although a small minority had indicated that this was less important to them.

The nurse lecturers were not alone in these feelings about the clinical role. At Stage 3, some of the clinical staff indicated that nurse lecturers should work actively in the clinical areas, but identified that since the merger into higher education they felt unclear about this aspect of the expected clinical role. One further problem to note was that, at Stage 3, the majority of clinical staff stated that they had experienced difficulties in getting in contact with nurse lecturers in University A since the merger into higher education. However, there may be several reasons for this. Firstly, many of the clinical nurses made reference to communication being made 'worse' because the nurse lecturers were not 'on site' (University A main campus was a mile away). Secondly, on attempting to contact nurse lecturers, clinical staff referred to the problematic answering and responding to telephone calls and a perceived lack of administration support.

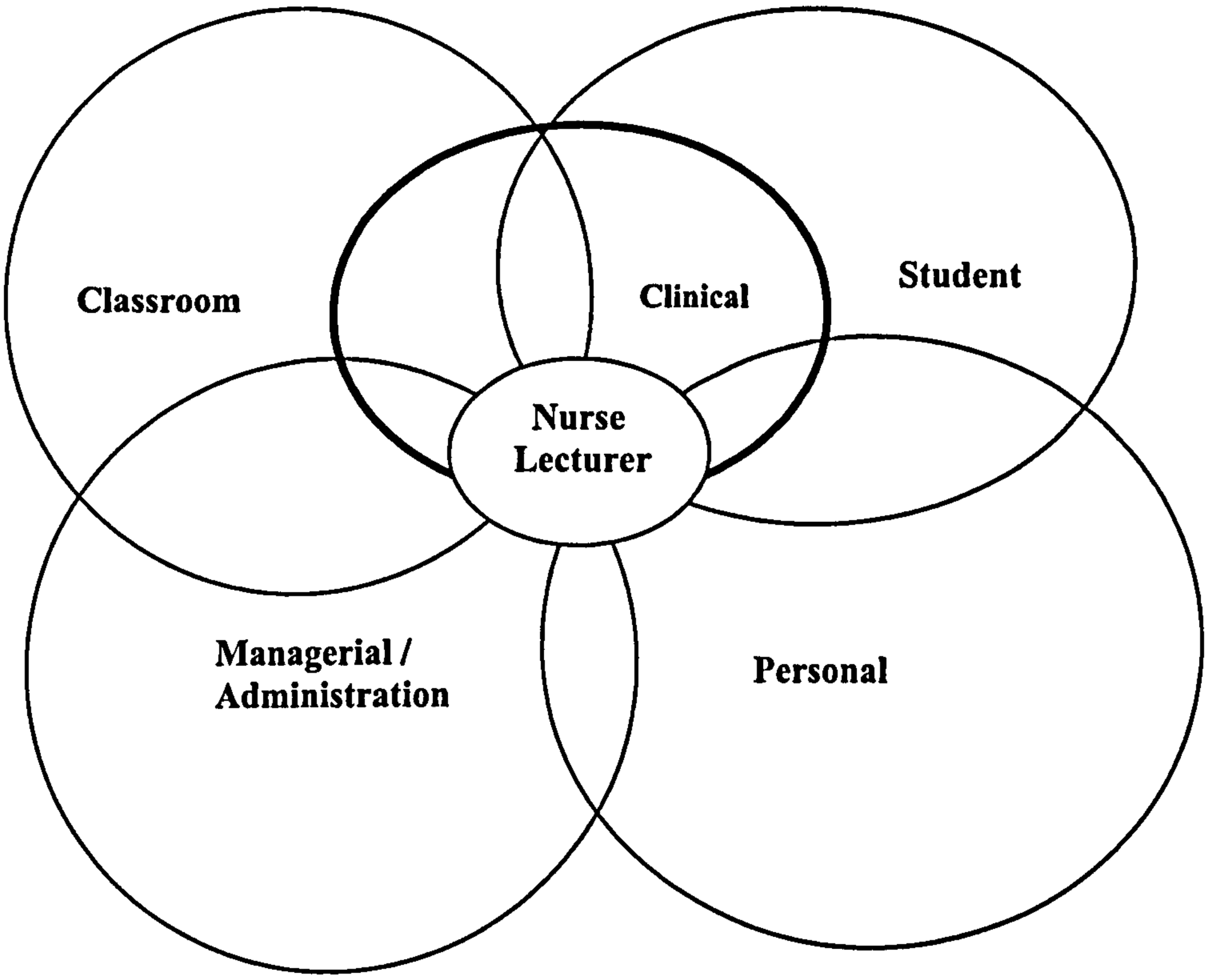
The loss or change in clinical role was thus strongly linked to the notion of a widening theory/practice gap since the merger into higher education. This was noted in the interviews of the nurse lecturers at Stage 2c and the clinical nurses at Stage 3. Such findings about the clinical role of nurse teachers was evident before the merger into higher education, but what the findings of this study could indicate is a change of perspective about the need for the clinical role and what it should entail. Interestingly, questions pertaining to the need for this role and how best to adapt this role in higher education culture resulted in a range of mixed responses.

Some nurse lecturers felt that this was part of the expected role and in not fully performing the role nursing credibility was affected. They also felt that if the

nurse lecturers' clinical skills were not up to date, then how could they teach clinical skills to nursing students? Certainly, given the recommended model advocated in the UKCC (1999) report (Chapter 2; Section 2.8.1), these are serious considerations. Alternatively, other nurse lecturers felt that a new, strategic partnership role with the clinical areas should be carved out for the nurse lecturer. Indeed, some felt that to be 'clinically credible' was not a necessary part of the role since the merger into higher education. Thus, they felt that their role as lecturers in higher education required new models for developing clinical links such as education advisor, consultancy work, and facilitating or undertaking research and publication activities.

Balancing the clinical role against other expected role attributes is clearly contentious for nurse teachers. Clifford (1995a) had suggested a model of 'role mastery' whereby the balancing of individual, professional and organisational conflicts were found to be difficult for the 'nurse teacher'. Coad (1994) also found that when 'nurse teachers' were faced with the dilemma of balancing the expected role attributes it was the clinical role that was often neglected, despite the importance and need to keep clinical skills up to date. Even though the findings reported here are several years later from Clifford (1995a) and Coad (1994), they would seem very relevant to the nurse lecturers in this study. Indeed, such issues could inevitably impact on role attributes and their relationship where one aspect is given more priority and time. With respect to the clinical role findings in this study, this has been exemplified in Figure 11.3.

Figure 11.3. The impact on the clinical role attribute when other attributes are given priority



Overall, such findings were interesting, as prior to the merger the potential for these problems had been noted in several research reports (Clifford 1993, 1995a, 1995b, 1996a, Barton 1998, Luker et al 1996). Furthermore, the findings of the most recent research undertaken on nurse lecturers since the merger into higher education also supported the confusion witnessed in this study surrounding clinical role (Evers 2001, Clifford et al 2001). The evidence for such propositions was also found in this study. This may reflect the changing nurse lecturer role attributes in terms of their expected clinical responsibilities

(and subsequent value of them) as a result of the merger into higher education, but would seem to be an important issue for future research.

11.3.4. Managerial and administration role

Key role attributes that emerged from the findings at all the stages of this study were marking, correspondence, meetings and course organisation. Overall course/module organisation was viewed as important by a large proportion of the nurse lecturers but at all the stages of the study reported, the managerial and administration roles were viewed as problematic. What was new was that findings suggested that, during the longitudinal stage of the study reported, the pressures of administration duties appeared to be rising in the universities studied and that subsequent role pressure was greater than in the college of nursing.

The focus of problematic issues did change over the stages and is worth noting here. Initially, at Stage 2a this was felt to be due to the large amounts of meetings as a result of the hierarchical culture. At Stages 2b and 2c, this was felt to be as a result of a loss of key personnel, an unequal distribution of work and lack of clarity about administration support. Common identified problems appeared to be the perceived lack of secretarial/administrative staff and that whilst resources such as individual computers/email access had increased this had added to overall workload.

At Stage 4, dissatisfaction was recorded specifically relating to the expected administration role. There were also mixed feelings about course/module

organisational aspects of the role and correspondence such as letters or phone calls. However, the role attribute of attending meetings was interesting. At Stage 2c the nurse lecturers had felt that in University A there were more meetings to attend than there had been previously in College A. On the other hand, at Stage 4 findings indicated that some respondents felt that this aspect of the role had low importance for them alongside a mixed satisfaction rate. Here a dichotomy of the nurse lecturer role might exist. For example, if nurse lecturers feel that the amount of meetings to be attended is not important do they simply not attend meetings or alternatively do they attend, but do not feel that this is a valuable aspect of their role? Such disparity of findings could possibly affect expected nurse lecturer role and subsequently contribute to role conflicts.

It is disputable whether marking student work is viewed as an administration role attribute or a responsibility that seeks to evaluate student development (Quinn 1988). As all nurse lecturers interviewed in this study stated this was a part of administration role attributes it will be discussed here. Whilst nurse lecturers indicated that marking was an important part of their role during the longitudinal stage of the study findings, they were most notable at Stage 2c. At this stage, nurse lecturers felt that there was discontentment about the amount of marking as part of their role attributes and that this was increasing. The reasons for this were felt to relate to the rising student numbers, the expected ongoing modular delivery and due to the loss of key personnel who had supported the marking process in the colleges of nursing. At Stage 4, findings revealed that whilst nurse lecturers felt that this was important, they were dissatisfied with this aspect of the role supporting the previous Stage 2 findings.

11.3.5. Personal role attributes

Key attributes identified in the findings were communicating with colleagues and senior managers, academic experience, role autonomy and personality traits such as possessing questioning, adaptation and networking skills, being motivated, a positive role model, hard working and creative. The level of personal role attributes was clearly an important feature at all stages of this study, but some of these changed in 'importance' over the longitudinal time span.

What remained an important role attribute throughout the study was the need for nurse teachers to communicate with one another. Arguably, this went beyond the boundaries of possessing good communication skills, as nurse lecturers at Stage 2 were able to cite many examples that facilitated their role, such as the need to be resourceful, professional sharing and drawing on experience. Sackmann (1991 pp 98) notes that such attributes are crucial in organisational mergers. However, the actual level of communication with colleagues appeared disproportionate, in that some nurse lecturers appeared contented whereas others were not. There are several considerations for this, one being that whilst role autonomy was viewed as an advantage of the higher education culture, but could also be a source of work isolation. Moreover, work isolation emerged as a concept at Stage 2c, and from the qualitative findings at Stage 4, about which several nurse lecturers cited reasons as geographical location of staff and increasing personal workloads and responsibilities. These are worthy considerations in the recruitment and retention of nurse lecturers (Coad 2002).

Communication with senior staff was felt to be important in role delivery at Stages 2a and 2b, but reduced considerably in relevance at Stage 2c. At Stage 4, some nurse lecturers were satisfied with this model whereas others felt that they were not. A number of possible considerations may play a part. In the colleges of nursing, the model has been described as 'hierarchical' whereas in the HEIs has been described as 'flattened'. It would follow in the latter model that there is less managerial staff for the nurse lecturers to communicate with and whilst some nurse teachers 'enjoyed' this, others did not.

Personality traits also changed during the study reported. Some traits were felt to be required at all stages of the study such as having a positive attitude, possessing questioning skills, being motivated and adapting to the new culture of higher education. At Stages 2a and 2b networking had been perceived as less important in the role, but at Stage 2c this was viewed as important. At Stage 2c it was also noted that some nurse lecturers 'enjoyed' more academic opportunities than other, which was related to a mixture of self-drive, being hard working and individual personality. Other new traits at Stage 2c, such as the need to be creative were identified. In part this may relate to the expected higher education culture but one aspect of creativity is the need to network, which would seem to connect such emerging traits (Coad and Devitt 1999).

However, this study also found mixed feelings about networking opportunities in the HEIs studied at Stage 4 where some respondents were satisfied but others were not. There is a potential dichotomy in this situation, as arguably nurse lecturers, like other professional groups need avenues to communicate, share

professional issues and develop ideas. Why some felt that they were satisfied with these aspects whilst others did not is not only interesting but would seem to relate to the adaptation of the nurse lecturers in their new role in higher education overall. Why and how a large proportion of respondents felt that they had adapted to their role in higher education whereas others had not could relate to the individual personality of the nurse teacher and findings appear to support this.

11.4. Recommendations – A model for the future

From the literature review it was noted that some authors had attempted to make recommendations about the nurse lecturer role in higher education (ENB 1998, Barton 1998, Evers 2001, Clifford et al 2001). From the findings of this study what is strongly indicated is that there needs to be serious consideration to the 'preferred' model for nurse education in HEIs and that much needs to be done to help lecturers of nursing evolve in the roles expected of them in higher education. This section will therefore outline recommendations with potential options for a model for the future.

11.4.1. Organisational culture

- There needs to be greater awareness of the cultural differences between the NHS and HEI, for both present nurse lecturers and for future recruitment. Given the lack of understanding about higher education culture indicated in this study it is crucial that when nurses are recruited they fully understand the organisational culture of higher education, and of the university recruited to. They need to be aware of the differences and what that might mean to them in that it is not simply a new job, but a new organisational culture and so has implications for the expected role and work conditions.

- A full assessment of nurse lecturer workloads within and across HEI needs to take place locally and nationally to explore issues pertaining to development issues such academic, research and publication activities equity of workload in comparison teaching activities.

- Given the transition issues, noted in this study, there needs to be proactive organisational commitment for the body of existing nurse lecturers currently in posts in HEIs. This should include development of support systems and improved career plan advice. Indeed, as issues of promotion and leadership

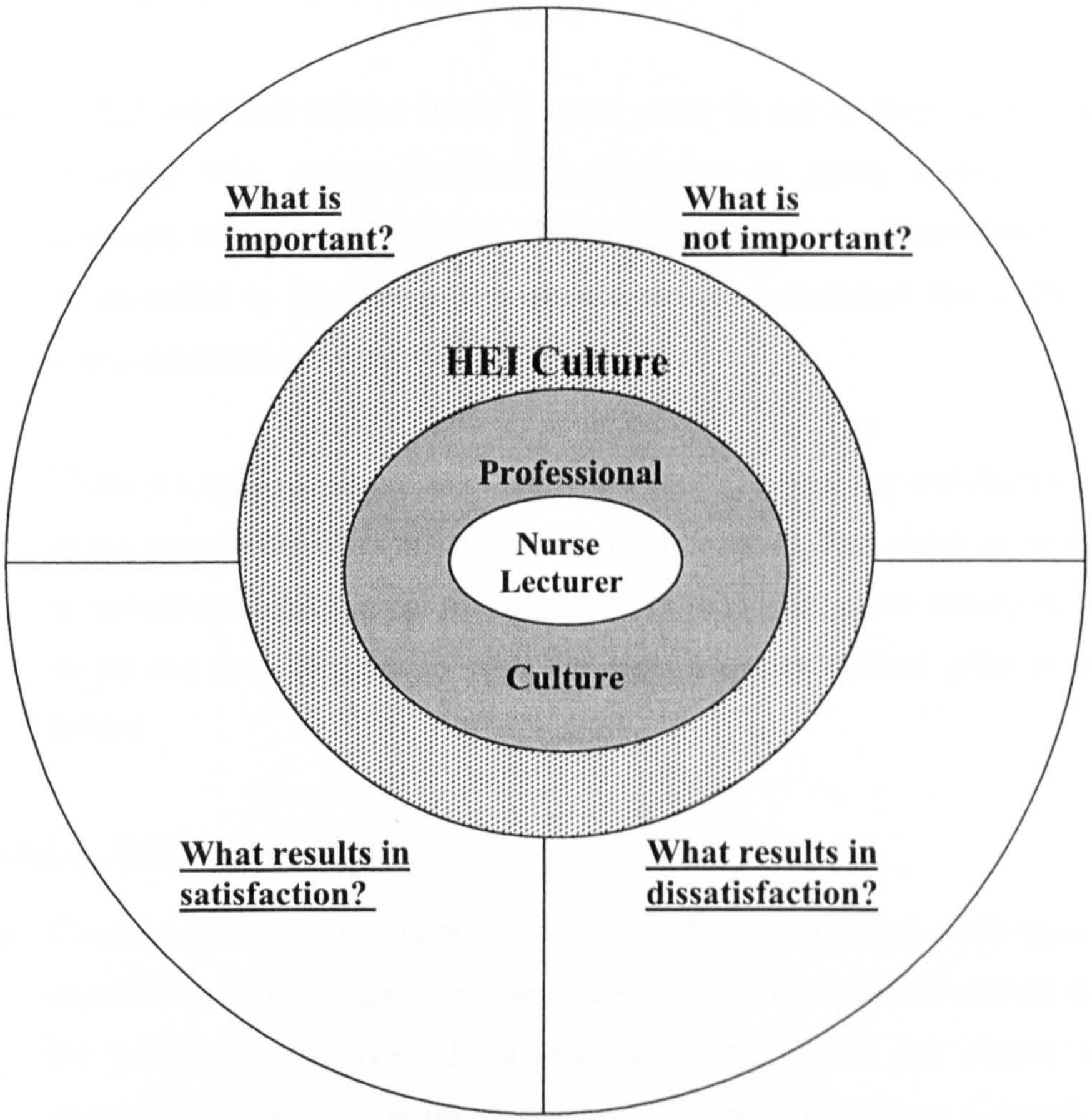
were highlighted, lecturing staff in nursing should be offered leadership programmes and opportunities that are widely available to NHS staff.

- Nurse lecturers need help to develop strategies of cultural acceptance such as that noted through understanding related to higher education culture, given titles and awards, role and networking activities. Perceived autonomy and need for creativity should be used to the advantage of the individual and the organisation.

- The evidence of this study shows that the nurse lecturer role has always been multi-faceted and that this role conflict has continued in HEIs. In the light of later evidence (Evers 2001, Clifford et al 2001) the differing needs of multiple stakeholders (HEI, Consortia Confederations, Council of Deans, NHS Trusts, National Boards, UKCC, RCN and nurse lecturers themselves) appear to add to the role conflict of nurse lecturers, there needs to be closer consultation and collaborative strategies implemented in order to enhance partnerships.

- A strategic vision is needed within HEIs to enable nurse lecturers to carve out a role, which they are personally satisfied with, but one that also meets with the organisational requirements. A model for assessing both the needs of the organisation (macro level) and the needs of the individual (micro level) is presented in Figure 11.4.

Figure 11.4. Cultural model for use in exploring the nurse lecturer role



11.4.2. Role Clarity

- Given the lack of role clarity with respect to the identified attributes of this study there is an urgent need to have clearer guidelines made available about the expected role of the nurse lecturer in higher education.

- A full workload review needs to take place in universities of the nurse lecturers' role, noting specifically the issues of parity across the role attributes of classroom, student, clinical administration and personal issues, as identified in this study. This should seek to understand the conflicting issues related to the nurse teacher role.

- There is a need to review specifically the expected teaching and clinical role of the nurse lecturer, as the two are so inter-twinned. This needs to be a full review of what the clinical role means to an individual nurse lecturer (micro level) and how this fits in with the organisational cultural goals (macro level).

11.4.3. Role Development

- Communication with university-based and clinical-based colleagues is essential to nurse lecturers and their development. Professional sharing must be facilitated. Positive educational initiatives should be shared and opportunities provided, within and across HEIs and NHS trusts, using all the available channels of communication, both in the local and national context.

11.5. Limitations

In any study Holloway and Walker (2000) suggest that limitations should be reflected upon in order to critically evaluate the final piece of work. On reflection, one limitation in this study was that data was collected at a time of much instability and change. Whilst it was the aim of the study to explore the impact of this change on the nurse lecturer role, the researcher was also a nurse lecturer experiencing a merger from a NHS college to a HEI. As outlined elsewhere (Chapter 6), such inside researcher issues can add strength to a project, but equally can create considerable bias. The issues pertaining to trustworthiness (Chapter 6; Section 6.7) aimed to overcome this.

A further consideration was the research tools that were developed specifically for this study and as such have not been subjected to wider testing for reliability and validity. It is also acknowledged that overall small numbers and only three universities (Universities A, B and C) were used. It is inevitable that each university will have its own organisational culture that differed from one another. This makes it difficult to claim the observations reported here are relevant to all HEIs. Nevertheless, it is hoped the insights reported will prompt consideration of local issues elsewhere.

Much consideration was given to the triangulation of data. As noted elsewhere, (Chapter 6; Section 6.3.1), that whilst methodological triangulation did occur, triangulation of findings across the stages did not occur. It was felt that the findings from Stages 2 and Stage 3 were felt to stand in their own right as qualitative findings. Thus, as Holloway and Wheeler (2000) notes in triangulating results there is a danger that the quantitative data, by the volume of

numbers dominates the rich, emerging picture of the qualitative findings. Care was taken to avoid this in the study, but the risk is noted.

The timing of the data collection in this study also needs consideration as Stages 2, 3 and 4 were prior to the UKCC (1999) report. As outlined in Chapter 2 (Section 2.6), this document called for radical change to the nursing curriculum and precipitated a philosophical shift in ways that nurse lecturers' work with the many stakeholders of nurse education. This would require further study to review the impact of this shift on the nurse lecturer role.

11.6. Conclusion

Overall, the study reported was a substantial piece of work, which explored the role of nurse lecturers as a result of nurse education transferring from colleges in the NHS to HEIs. The findings were most interesting and indicated that, whilst the majority of nurse lecturers had settled into their roles as lecturers in higher education, some did not understand the organisational culture within which they worked. Arguably then, some of their assumptions about the organisation remain untested and could make role adaptation more difficult. A concern must be therefore, whether the nurse lecturer role has changed significantly since the nurse teachers, used here were staff in the NHS. If some nurse lecturers are still performing the NHS 'nurse tutor' role, whilst others have developed their role as lecturers, then this must impact on their role in terms of expectations, performance and consequently satisfaction. Such disparity in role as indicated in this study is disturbing and strongly indicates that all the parties concerned should give serious consideration to the shared vision in the future planning of the nurse lecturer role.

On reflection, the framework used in the study was useful in mapping the nurse lecturer role from both the perspectives of nurse lecturers and clinical nurses. Moreover, the framework that emerged from the findings may be used to explore the roles of other professional groups in HEIs. Reviewing role attributes from an organisational cultural perspective has generated a wealth of new knowledge about the role of nurse lecturers. Indeed, this study has highlighted the complex role of nurse lecturers now that they are no longer 'nurse tutors' but are 'lecturers' within the organisational culture of HEIs.

It is also hoped that this study will be useful for future recruitment and retention of staff, as the insights gained may help lecturers understand more fully their roles in HEIs. Therefore, the findings from this study not only have implications at the micro level of helping nurse lecturers to adapt, but also from the macro level of the organisation. It is thus felt that there is a need for further work in the field in order to understand the nurse lecturer role more fully. This is particularly important if aspects of role conflict highlighted in this work are to be addressed positively in the future.

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Appendix 1

Concepts related to role using the example of nurse teacher role

Adapted from Biddle & Thomas (1966)

1. Role Concepts for the person

This encompasses all those concepts used to apply to persons such as individual, ego, self, every person and group. In health care situations examples would include doctor or nurse whilst their specific characteristics are cited as the ward sister, the consultant, the practice nurse. In relation to the role of a nurse teacher a behavioural concept for the person may be that of nurse teacher, tutor or lecturer in nursing.

2. Role concepts for behaviour

Concepts relating to behaviour which divide into specific concepts as outlined below:

- Behaviours with a specific concept such as *norm* or *performance.*
- Actions, often learned previously or attained such as *school performance, leader* or *follower.*
- Prescriptions associated with behaviour such as *role expectations*
- Evaluative behaviour which are often positive or negative such as *reward* or *punishment.*
- Descriptive behaviour often representing events such as *role descriptions, anticipations, subjective* role or *role probability.*
- Sanction behaviour when it is engaged to change some other behaviour (and of similar structure to evaluative) such as *ratification* or *custom.*

Using the specific concepts outlined nurse teacher behaviour must therefore impact on the role they perform. Arguably, this would alter 'from time to time and place to place' depending on factors such as the organisation, responsibilities, culture and the persons who they interact with (student nurses, clinical staff or academic colleagues).

3. Role concepts for persons and their behaviours

This category combines both those concepts pertaining to the person and the behaviour, which Biddle & Thomas (1966) purport is even more dynamic. This encompasses Linton's (1936) work in that those individuals in any given society will exert themselves through their perceived position. This may refer to their occupational role such as teacher but uses specifically their namesake such as 'MacGregor' belonging to a specific clan. In this way the person is identified i.e. 'Mr. MacGregor is our teacher and he is from Scotland'. However, this may be incorrect.

With respect to the nurse teacher, the title might imply to individuals that the role involves some form of clinical nursing skills. Some nurse teachers continue to work in practice undertaking clinical skills and this assumption will be correct. If on the other hand they do not this may be a 'false assumption'.

Appendix 2

The process of concept analysis work

Adapted from Walker & Avant 1995

1. Select a concept

2. Determine the aims/purpose of the analysis

3. Identify all uses of the concept

4. Determine the defining attributes

5. Construct a model case

6. Construct additional cases:

- Borderline
- Related
- Contrary
- Invented
- Illegitimate

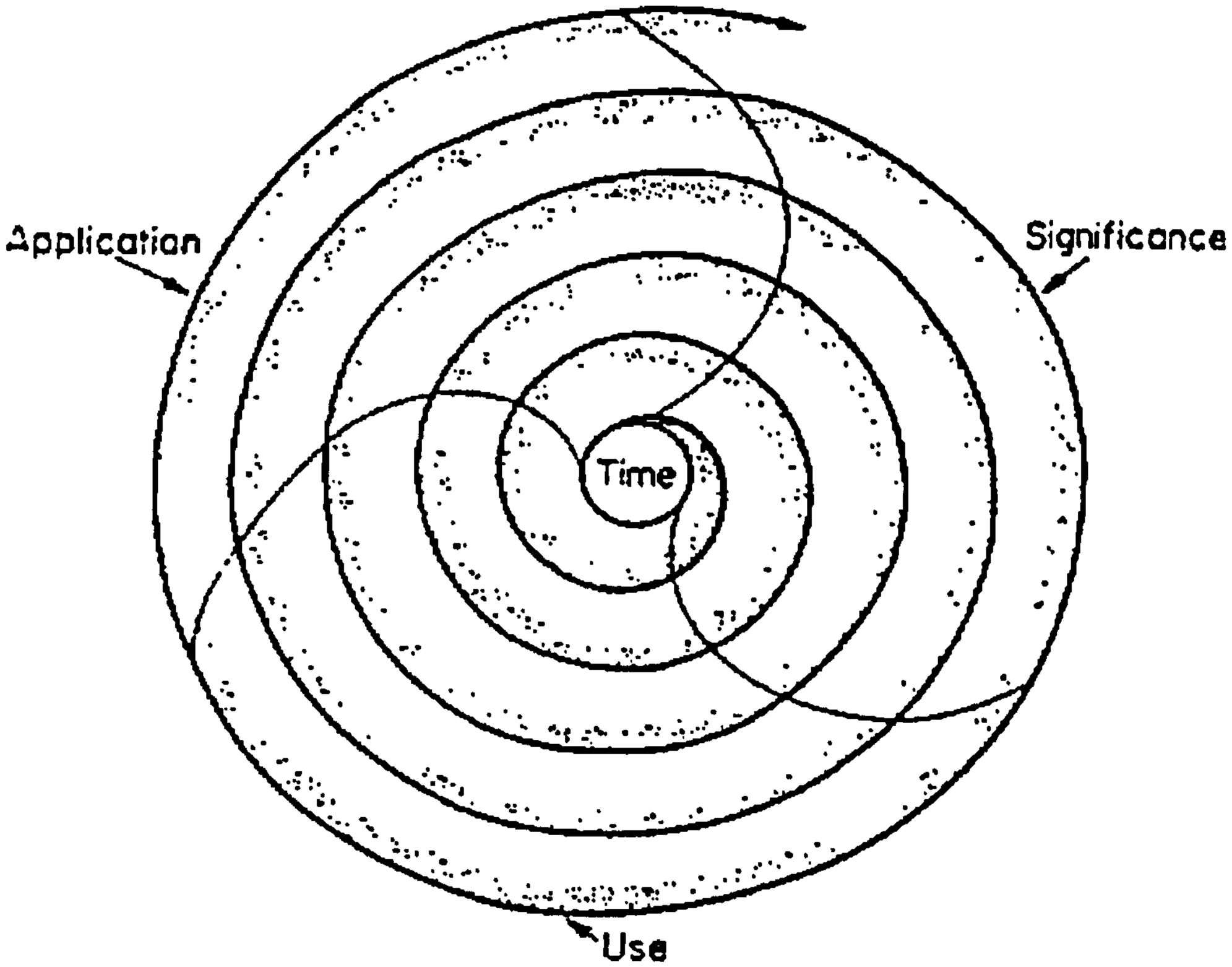
7. Identify antecedents and consequences

8. Define empirical referents

Appendix 3

Cycle of concept development

Adapted from Rodgers (1989)



Appendix 4

The process of concept evaluation

Adapted from Morse et al (1996)

Breakdown the anatomy of a concept to include:

- A definition
- Characteristics
- Boundaries
- Preconditions
- Outcomes

Appendix 5

Mapping the word: Teacher

TEACHER =

Mentor
Master
Educator

Mentor =

Instructor
Trainer
Tutor
Facilitator
Coach
Manager
Educator
Guru
Champion
Preceptor

Master =

Adept
Skilled
Practised
Proficient
Expert
Leader
Governor
Governess
Pedagogue
Schoolmaster
Principal

Educator =

Preceptor
Mentor
Master
Learner and scholar
Lecturer
Professor
Reader
Tutor
Guru
Instructor

Appendix 6

Mapping the word: Lecturer

LECTURER

Teacher
Speaker
Orator

Orator

Speaker
Public Speaker
Address
Talker
Administrator
Takes lessons
Articulates
Conveys
Teacher
Utterer

Speaker

Public Speaker
Utterer
Talker
Orator
Conversationalist
Lecturer
Broadcaster
Elocutionist
Preacher
Delegate
Spokesperson
Pulpiteer

Teacher =

Mentor
Master
Educator

(See Appendix 5)

Appendix 7

SEMI-STRUCTURED INTERVIEW FRAMEWORK

Used at Stage 1 with nurse teachers, clinical staff, students and university lecturer.

1. Can you tell me your background information/ biographical details? (Include – age, qualifications, length of time in post)

2. What is your current job title?

3. Can you tell me three of your current role attributes which you possess?

4. What is your understanding of the culture/organisation of the college/university?

5. What do you think this merger will mean (has meant) to nursing education and training?

6. What do you know about the nurse teachers' role?

7. Do you feel nurse teachers role will change (Organisational and personal preparation?)

8. Can you give me three benefits of the nurse teacher role/nurse education being in higher education?

9. Can you give me three problematic issues of the nurse teacher role /nurse education in higher education?

Appendix 8

SEMI-STRUCTURED INTERVIEW FRAMEWORK NURSE TEACHERS Stages 2a, 2b and 2c

1. Age group? Background information?

2. What is your current job title? What is your preferred title?

3. Nurse education as a career?/ Career path do date

4. Can you tell me your qualifications? / Qualifications since last interview?

   Prompt : Nursing qualifications/experience
   Academic qualifications/skills
   Personal

5. Can you tell me your current role attributes that you feel you possess?

   Prompt : Classroom
   Students
   Clinical
   Managerial/Administration
   Personal

6. What is your understanding of the culture/organisation of the college/university?

   Prompt : Philosophy
   Rules
   Hierarchy
   Strategies of management
   Organisation of work
   Communication pathways
   Curricular Delivery & developments

7. What do you think this merger will mean (has meant) to nursing education and training?

   Prompt : 3 positive
   3 problematic

8. What organisational preparation have you had (or did you have) for the merger into higher education?

Appendix 8 continued

Prompt: Organisational strategies employed
University arrangements
Status
Promotion
Development opportunities including academic, research, management, publication profile

9. What personal preparation have you had (did you have) for the merger into higher education?

Prompt: Personal strategies employed
Contacts
Adaptation to rules
Status
Promotion
Development opportunities including academic, research, management, publication profile

10. What do you feel will be your future role attributes within higher education? How will your role develop in the future?

Prompts : Change envisaged
Strengthening of role
Classroom
Students
Clinical
Managerial/Administration
Personal

11. Can you give me three benefits of your role (perceive or actual) from working in higher educational?

12. Can you give me three problematic issues of your role (perceive or actual) from working in higher education?

Appendix 9

SEMI-STRUCTURED INTERVIEW FRAMEWORK
CLINICAL NURSES Stage 3

1. What is your current post? Length of time in post/age group? Biographical?

2. What is current role with respect to supervision of students?

3. Can you tell me what you know about the current merger of the College of Nursing with Higher Education Institutions?

Prompts: History
Educational issues
Contracts
Nurse teachers' role
Impact on clinical links

4. What do you think this will mean to the education and training of nursing?

Prompts: 1 positive/1 problematic

5. What do you think this will mean to the practice of nursing?

Prompt: 1 positive/1 problematic

6. What current contact do you have with nurse teachers?

7. What title would you use when communicating with nurse teachers ?

8. What contact do you have with nurse teachers?
How do you contact a nurse teacher if you have a problem/question?

9. What 3 attributes do you think are CURRENTLY required for this role?

10. What 3 attributes do you think will be required in FUTURE for this role?
Suggest ways for nurse teacher role development?

Appendix 10a

Letter sent to staff in University B and C

February 1998
Dear Colleague

I am a Senior Lecturer from the University of Central England and have been registered on my Master of Philosophy/PhD for two years at Wolverhampton University. The title of the study is '*An investigation into the impact on nurse teachers as a result of nurse education transferring into higher education*'.

The focus of the project has been to explore perceptions of a group of nurse lecturers with respect to their role as they moved from working in colleges of nursing located in the National Health Service to nurse lecturers in Higher Education. In addition, a group of clinical nurses have been studied in order to explore their perceptions of the nurse lecturers role and the subsequent impact of the merger on nursing.

I would very much now like to validate my baseline findings and would like you to help me by completing the enclosed questionnaire. If you agree, pre-testing has shown that it will take approximately fifteen minutes to complete after which it will need sending in the internal envelope provided to ... by Monday March 16th 1998. I can assure you of your anonymity, that all the details you give me will be kept strictly confidential and that I sought permission from ... Dean of School to approach you.

I hope you agree that the information gained will not only be useful to nurse lecturers in Higher Education but also to all nurses in both the teaching and delivery of nursing. I would therefore very much appreciate your help in responding to the questions. If you are unsure about any of the questions or require additional information about the project please do not hesitate to contact me at the above address and telephone number.

Thanking you in anticipation

Yours sincerely

Jane Coad
Senior Lecturer

Appendix 10b

Questionnaire used at Stage 4

Nurse Teacher to Lecturer in Nursing?

Instructions for completion

1. Please complete all of the 8 questions

2. At the beginning of each question there is an instruction in bold, underlined to help you to complete the questionnaire.

3. Please feel free to add any additional comments of your own in the space provided

4. After completion please enclose in the provided internal envelope and send to .....

Thank you for your co-operation

Jane Coad

Nurse Teacher to Lecturer in Nursing?

Jcquest98

1. Please tick the box which MOST applies to you

In which age group do you belong ?

Under 30 years	☐
31 – 40 years	☐
41 – 50 years	☐
Above 50 years	☐

2. Please tick the box which MOST applies to you

How long have you been in nurse education?

Less than 3 years	☐
3 to 6 years	☐
7 to 10 years	☐
11 to 15 years	☐
More than 15 years	☐

3. Please tick the boxes which MOST apply to you

Why did you choose to enter nurse education?

Self development	☐
Advised to	☐
Convenient hours	☐
Enjoyed teaching	☐
Opportunity of academic development	☐
To act as a role model to other nurses	☐
Opportunity for research development	☐
Better pay	☐
Autonomy	☐
Other (Please specify)	☐

4. <u>Please list your main academic, professional and teaching qualifications</u>

1. Academic –

2. Professional –

3. Teaching –

5. <u>Please tick the box which MOST applies to you</u>

What is your current title?

Lecturer in Nursing	☐
Senior Lecturer	☐
Senior Lecturer in Nursing	☐
Principal Lecturer	☐
Other (Please specify)	☐

6. <u>Please tick the box which MOST applies to you</u>

What title do you use on the telephone to clinical staff?

Nurse Tutor	☐
Nurse Teacher	☐
Lecturer in Nursing	☐
Senior Lecturer	☐
Senior Lecturer in Nursing	☐
Principal Lecturer	☐
Other (Please specify)	☐

7. <u>Listed below are a number of statements to explore your perceptions of YOUR nurse lecturer role.</u>

<u>Please CIRCLE the number that you MOST feel relates to your feelings</u>

<u>Key to Scale</u>			
	Strongly Agree	**=**	***SA (Number 1)***
	Agree	**=**	***A (Number 2)***
	Neither Agree/Disagree	**=**	***NA/D (Number 3)***
	Disagree	**=**	***D (Number 4)***
	Strongly Disagree	**=**	***SD (Number 5)***

	SA	***A***	***NA/D***	***D***	***SD***
7.1. In the Higher Education system my chances of promotion are limited	**1**	**2**	**3**	**4**	**5**
7.2. Working in Higher Education does not give me more status than previous work in the National Health Service	**1**	**2**	**3**	**4**	**5**
7.3. I have made many NEW local & national contacts since the merger into Higher Education	**1**	**2**	**3**	**4**	**5**
7.4. Nurse Lecturers are in a prime position in their role to teach the theory that underpins nursing such as frameworks of care	**1**	**2**	**3**	**4**	**5**
7.5. I feel that the work isolation is LESS since the merger into higher education	**1**	**2**	**3**	**4**	**5**

7.6. I feel that the majority of nurse lecturers have had difficulty in adapting to the 'rules' of Higher Education	**1**	**2**	**3**	**4**	**5**
7.7. Nurse Lecturers must keep clinical skills up to date if they are to teach student nurses	**1**	**2**	**3**	**4**	**5**
7.8. I feel that the pressures of undertaking the nurse teacher role are greater in higher education than in the college of nursing	**1**	**2**	**3**	**4**	**5**
7.9. I feel that I have adapted to higher education because of my own personality	**1**	**2**	**3**	**4**	**5**
7.10. I feel that student progression is better in higher education	**1**	**2**	**3**	**4**	**5**

7.11. Can you identify ONE benefit of working in higher education institutions?

7.12. Can you identify ONE problem of working in higher education institutions?

P.T.O.

8. <u>Listed below are a number of factors that may be attributed to the nurse lecturers role.</u>

Please indicate with a TICK on the scale the extent to which you are SATISFIED with the aspects and then rate how IMPORTANT they are to you.

	Satisfaction					Importance				
	Very dissatisfied				Very Satisfied	Not important				Very important
	1	2	3	4	5	1	2	3	4	5
1. Opportunities to develop clinical skills	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Visiting students on Placements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Communication with clinical staff	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Opportunities for own academic development	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Opportunities for own research development	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Opportunities for own publication profile	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Opportunities to be involved in managerial decisions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Opportunities to network	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Communication with senior faculty staff	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Appraisal system in use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Autonomy of job requirements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Variety of teaching commitments	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Job contract	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Office space	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Administration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Question 8 continued

	Satisfaction Very dissatisfied 1 2 3 4 5 Very Satisfied	Importance Not important 1 2 3 4 5 Very important
16. Status as a lecturer	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
17. Marking of assignments	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
18. Supervision of students e.g. tutorials	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
19. Course / Module Organisation	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
20. Teaching of students in lectures/ formal sessions	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
21. Teaching of students in seminar groups	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
22. Support/Counselling of students	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
23. Communication with individual students	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
24. Communication with students as a group	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
25. Communication with work colleagues	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
26. Flexibility of work hours	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
27. Correspondence e.g. letters or phone calls	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
28. Time to develop clinical skills	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
29. Time to undertake expected role	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
30. Meetings to be attended	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

Please add any additional factors that you consider important

Thank you for completing the questionnaire

Appendix 11a

Development of the questionnaire
Stages 2a, 2b and 2c significant data identified for questionnaire

Biographical data/ Career Plan

	Stage 2a	Stage 2b	Stage 2c
Findings	15 in nurse education for at least 2 – 14 years Age range of 30 to 42 years. All leadership experience within the nursing specialities of general/adult, mental health and paediatrics. Total clinical nursing experience ranged from 6 years to 19 years of service and all 15 teaching qualifications 13 worked as 'Unqualified Nurse Teacher'. Qualifications relevant to nurse teachers Reasons for choosing nurse education important but complex, personal information	Nursing specialities static Variety of teaching levels and students – pre and post registration work	Pre-registration courses (11) at Levels 1 and 2 Post-registration courses up to Level 3 (4) Degree supervision undertaken for research dissertation at Level 3 (Degree) Modular teaching fully accepted
Final key role issues	Age/biographical data Length of time as teacher Reason for choosing nurse education as a career Academic, professional and teaching qualifications	Variety of teaching important	Range and variety of teaching important Module organisation accepted
Questions developed	Question 1, 2, 3 & 4 – Biographical data Question 3 – reasons for entering nurse education	Question 1, 2 , 3 & 4 – Biographical data Question 3 – reasons for entering nurse education Question 8.12 – Variety of teaching	Question 1; 2, 3 & 4 – Biographical data Question 3 – reasons for entering nurse education Question 8.12; 8.19 – teaching responsibilities

Appendix 11a continued

Current job title/preferred title

	Stage 2a	Stage 2b	Stage 2c
Findings	Anticipation of change in title – 11 described themselves as 'Nurse Tutors'/ 4 stated 'Nurse Teachers'. No participant was in doubt about their title.	11 stated confusion about their titles / 'preference' of title 'Nurse Tutor' (8), 'Senior Lecturer' (2), 'Nurse Teacher' (1), 'Unsure' (4)	no confusion (15) Either Senior Lecturer (14) or Principal Lecturer (1). Clear in contracts Issues when dealing with clinical staff
Final key role issues	Current job title important	Unclear job title = feelings of uncertainty and increased anxiety	Clarity of title at university but change title when dealing with clinical staff
Questions developed	Question 5 and 6- Title issues	Question 5 & 6 – Title issues	Question 5 & 6 – Title issues

Appendix 11a continued

Current Role attributes

	Stage 2a	Stage 2b	Stage 2c
Findings	Time in classroom 'about right'. Student development important & teaching of theory (linking to practice) was problematic - larger student numbers Own clinical skill development(12). Clinical role problematic. Course organisation, marking, corresponding, meetings dominated the role. Lack of resources Academic experience & development essential. Good communication skills (15) with colleagues, senior managers, students and clinical staff and positive personality	Linking of theory to practice in the classroom (7) Large group sizes = problem in formal lectures/ one to one. Communication with students important Clinical skills needed to teach/ link role important Marking, meetings still dominated the role (7) More autonomy (5) Academic development +ve + opportunities and feeling a need to develop Communication with colleagues and senior managers needed (15). Adaptation skills / role conflict high (12). Lack of time/ role diversity problems. Need strong personality (10), +ve role model (5) & motivation (4)	Linking of theory to practice (14) Variety of teaching (9) Students important (10) but less than Stage 2b & 2c. Less pastoral support', larger sizes, higher wastage rates' and not knowing students. Need clinical expertise /skills but 4 given time. Time problem in role. ↑ time on administration. Managerial decisions within flattened structure but = more meetings attended by individual. Problems with promotion Communication crucial with students, colleagues, clinical staff, senior staff Less opportunities Self-driven culture (15) Academic development ↑ but research/publish less Diversity of demands (4) and ↑ workloads (3)

Final key role issues	Teach theory which relates to care Teaching, support, supervision & progression of students is important to role Teaching resources. Clinical role – time to develop skills/visit students. Communication with students, clinical staff, colleagues, senior staff important Course administration, marking, meetings,	Teach theory - relates to care. Teaching, support, supervision & progression of students important to role. Lectures/one to one supervision. Clinical role – time to develop skills/visits Communication with students, clinical staff, colleagues, senior staff Course administration, marking, meetings Role autonomy increase Increased anxiety Personality to adapt	Role Clarity Variety of teaching Teaching theory Students in lectures/ one to one issues Student communication Clinical role problematic Communication with students, clinical staff, colleagues, senior staff Appraisal system Autonomy & flexibility of role issues Office space Promotion issue
Current Role cont **Questions developed**	Question 8.18; 8.22; 8.23; 8.24 = student role attributes Question 8.1; 8.2; 8.3 & 8.28 = clinical role attributes Question 8.15; 8.17; 8.19; 8.27 & 8.30 = Managerial and Administration role Question 8.9; 8.13 and 8.25 = personal role attributes	Question 8.20 & 8.21 – lectures/seminars = classroom role Question 8.18; 8.22; 8.23; 8.24 = student role attributes Question 8.1; 8.2; 8.3 & 8.28 = clinical role attributes Question 8.15; 8.17; 8.19; 8.27 & 8.30 = Managerial and Administration role Question 8.9; 8.11; 8.13; 8.16 and 8.25 = personal role attributes	Question 8.12; variety of teaching = classroom role Question 8.18; 8.22; 8.23; 8.24 = student role attributes Question 8.1; 8.2; 8.3 & 8.28 = clinical role attributes Question 8.15; 8.17; 8.19; 8.27 & 8.30 = Managerial and Administration role Question 8.9; 8.10; 8.11; 8.13; 8.14; 8.16; 8.25; 8.26 & 8.29 = personal role attributes

Appendix 11a continued

Future Role attributes

	Stage 2a	Stage 2b	Stage 2c
Findings	Unclear re: future attributes - 4 felt that nursing expertise needed. 13 felt that academic qualifications /expertise 6 = Research /publishing activities	Noting differences of higher academic qualifications would be valued (14), role would be more 'autonomous' (10), research/publishing activities would be essential (9), develop professional awareness (8) wider networking (7),	O unsure about future in HEI Nursing experience required for role (4) whilst 10 felt link theory to practice whoever performed role Academic qualifications essential (15) Research and/or publishing expected but no specific pressure and limited opportunities More adaptation strategies (13) such as wider networking skills (11), new teaching strategies (9) and having greater cultural awareness of other professions than nursing (10)
Final key role issues	Academic development Research activities Publication profile	Academic development Research activities Publication profile Networking/Contacts Professional awareness	Change re theory /practice issues Academic development Research activities Publication profile Managerial decisions Networking/Contacts Professional awareness Adaptation strategies
Questions developed	Questions 8.4; 8.5 and 8.6 = future opportunities	Questions 8.4; 8.5; 8.6 and 8.8 = future opportunities	Questions 8.4; 8.5; 8.6; 8.7 and 8.8 = future opportunities

Appendix 11a continued

Current Cultural and Organisational Understanding

	Stage 2a	Stage 2b	Stage 2c
Findings	15 understood college cultural/organisation - clear formal and informal rules (12), +ve team work (8) well delineated managers, hierarchical (9), curricular development and delivery clearly defined with a clear purpose (5) but (3)felt this was slow	Rules unknown (10) more flexible and autonomous culture Some understanding of communication pathways and structure Confusion about work allocation (4) Felt wider choice and modular curricular delivery at the higher, academic levels (9) Concerns = larger groups sizes and more pressures to deliver Positives = clearer student progression, improved academic development for students and staff	Rules 'clear' (12) and participants 'settled'. Greater work flexibility Flattened structure viewed positively & accepted Issue of perceived power distribution - different opportunities being allotted unequally to staff More autonomous roles positive for self-development. Isolation noted ..some of this being geographical and some professional. More role pressures as demands greater = Time a problem
Final key role issues	Rules clear Organisation of work, course delivery clear Communication with senior staff good Managerial decisions clear but hierarchical Nurse teacher theory/practice role	Rules unclear. Adaptation needed Organisation of work, course delivery some confusion Flexible and autonomous culture Group sizes and pressures greater	Rules clear & adapted Organisation of work, course delivery clear Student progression Managerial decisions clear but disparity of opportunities re: theory/practice Autonomy/Flexibility Work Pressure Contacts changed Isolation/contacts Office Space Promotion Status
Questions developed	Question 8.9; 8.19 and 7.6 = rules/organisation 7.4. = Nurse teacher role	Question 8.9; 8.19; 7.6; 7.8. = work related rules and culture	Question 8.9; 8.19; 7.1; 7.2; 7.3; 7.5; 7.6; 7.8; 7.9 = rules/adaptation 7.10 = student progression 7.4 and 7.7 – culture re theory/practice role

Appendix 11a continued

Personal Higher Education Information

	Stage 2a	Stage 2b	Stage 2c
Findings	15 felt little personal preparation had occurred – communication with colleagues	15 used their own communication channels 11 union representation' 9 read some published literature 4 own experience of student in a university	Colleagues and fricnds at both formal and informal meetings (15) Informal nctworking & contacts essential due to the 'isolation' Status Adaptation
Final key role issues	Communication with colleagues important	Communication with colleagues important and own adaptation skills	Communication with colleagues important and own adaptation skills Adapted to role
Questions developed	Question 8.25 – communication	Question 8.25; 7.6 and 7.9 – Personal strategies	Questions 7.2; 7.3; 7.5; and 7.9 – Personal strategies

Organisational Higher Education Information

	Stage 2a	Stage 2b	Stage 2c
Findings	15 had informal meeting with line manager and/or teams & 4 a 'formal' union meeting but 0 from University A. Feeling of powerlessness was high	'welcome study day' at University A (15) felt like a 'take-over' (8) and 'unwelcome' (4). job contracts were important but still being negotiated (13)	University-led 'formal' meeting attended (15) Communicate with line manager (14) and appraisal experienced (12) Nursing issues within university (12) Not meet up enough as a large group (15) Pressures greater
Final key role issues	Powerlessness	Merger anxiety Job Contract	Pressures Promotion
Questions developed		Question 8.13	Question 7.1; 7.8 = organisation higher education information

Appendix 11a continued

Benefits of role in higher education

	Stage 2a	Stage 2b	Stage 2c
Findings	Develop professional base of nursing (15), increased job status in university (9), self development (9), publish or be involved with research activities (6) & increase in academic development (6)	Development of nursing (14) Increased job status (13) Research / publication development (10), Increase networking opportunities (9), Greater self personal development (9) Awareness of flattened structures	Develop professional base of nursing (15), increased networking opportunity (11) flattened' structure(8), opportunity to develop personal (12), academic (13) and research/publication profiles (4). More job satisfaction (8)relating to job contract terms and 'job status'
Final key role issues	Job status Job contracts Academic development Research activities Publication profile	Job status Job contracts Academic development Research activities Publication profile Networking opportunities	Networking Flattened structures University arrangements = opportunities Job status Job contracts Academic development Research activities Publication profile
Questions developed	Question 8.13, 7.2; 8.16; 8.4; 8.5 and 8.6	Question 8.13, 7.2; 8.16; 8.4; 8.5 and 8.6	Question 7.2; 8.4; 8.5; 8.6; 8.8.; 8.13 and 8.16 Open ended – qualitative information

Appendix 11a continued

Problematic issues of role in higher education

	Stage 2a	Stage 2b	Stage 2c
Findings	loss of clinical skills (15), perceived wider theory / practice gap (9), change of organisational structure (7) & increased research/academic pressures (4) = increased stress (7)	potential loss of clinical skills (14) ↑ theory / practice gap (9) Adaptation issues - 'nurse tutor' to new 'nurse lecturer' role. Problems = change of teaching style (10) & organisational structure (7). Increased anxiety and stress (14)	Opportunities and time to develop clinical nursing skills (15) = wider theory / practice gap (14) Large organisation = '*nursing not valued*', '*not distinct'* and '*not being in the NHS'* (13) Increased amount of marking (11), meetings (9) and administration (8) Variety of teaching (12) & changed teaching style - large group teaching (8) Isolation (7) Increased autonomy in decision –making but less in the organisation (3 Unclear information – less direct communication (2) Research and academic demands (3) were considered less problematic
Final key role issues	Clinical skill development Increased pressures	↑ theory / practice gap new 'nurse lecturer' role = more pressure	↑ theory / practice gap new 'nurse lecturer' role = more pressures Communication Autonomy Disparity of opportunities
Questions developed	Question 7.7; 7.8; 8.1 and 8.28	Question 7.4; 7.7; 7.8; 8.1 and 8.28	Question 7.4; 7.7; 7.8; 8.1; 8.4; 8.5; 8.6; 8.7; 8.9; 8.11; 8.23; 8.24; 8.25; 8.26 and 8.28 Open ended – qualitative information

Appendix 11b

Development of the questionnaire
Stage 3 significant data identified for questionnaire

Contextual information

	Stage 3 Findings Clear in the expectations of the supervision role (15)
	Final key role issues Clarity of need re: supervising role
	Questions developed (Appendix 10b) None specific to nurse teacher role

Perceptions about the merger into higher education

	Stage 3 Findings Unclear re: merger event (17) Problematic theory /practice gap (14) Content too theoretically based /not enough practice Increased professional status (15) Better student facilities (10) More educational opportunities (14) Better academic qualifications (9) More research development (9) Lack of clear focus/rising student numbers
	Final key role issues Greater opportunities Greater pressures & expectations were high Theoretical input vs. practice input (role)
	Questions developed (Appendix) Questions 7.4 & 7.7 Theory/practice role Questions 7.2 and Questions 8.16 Professional Status Questions 8.4; 8.5; 8.6 Nurse teacher opportunities Question 8.20; 8.21; 8.23; 8.24 and 7.10 Student teaching issues

Appendix 12

Final focused areas of the questionnaire

Questions 1 to 3
Includes biographical profile of nurse teachers
Length of time in nurse education
Reasons for entering nurse education

Question 4
Academic, professional and teaching qualifications

Questions 5 to 6
Current Job title
Title used on the telephone to clinical staff

Question 7
Promotion
Status
Contacts with other university lecturers
Teaching of theory /Teaching of clinical skills
Work isolation
Adaptation to rules
Up date of clinical skills
Work related pressure
Adaptation
Student progression

+ One benefit/problem of working in higher education = open ended

Question 8 (Framework identified in the literature review)

Classroom Role – teaching variety, formal lectures and seminar groups.

Student Issues – supervision, support/counselling, communication individual and in student groups.

Clinical Role – opportunities, visiting students, communication, and time given for clinical skills.

Management/Administration – administration, marking, course/module responsibilities, correspondence and meetings.

Personal – communication senior staff, appraisal, autonomy, job contract, office space, status, communication with colleagues, flexibility, time for role.

Future - academic, research, publication profile, management, networking opportunities

Appendix 13a

Letter sent to 5 participants at Stage 4a (Test-retest)

December, 1997

'*An investigation into the impact on nurse teachers as a result of nurse education transferring into higher education*'.

Dear Colleague

Following our conversation, I have for two years being studying the above titled project, the focus of which has been to explore perceptions of a group of nurse lecturers using interviews. The aim of the study was to explore their role as they moved from working in colleges of nursing located in the National Health Service to nurse lecturers in Higher Education. In addition, a group of clinical nurses have been studied in order to explore their perceptions of the nurse lecturers' role and the subsequent impact of the merger on nursing.

I would very much now like to validate my baseline findings and have constructed a questionnaire from their findings for use in two universities in the West Midlands. Prior to the questionnaire being sent the universities, I would very much like you to help me by 'testing' the enclosed draft questionnaire.

I would therefore like you to complete the questionnaire and add any comments to the feedback sheet. **Please can you return this first questionnaire and feedback sheet within two weeks in the stamped address envelope provided.** Following your comments, I will amend the questionnaire and will send you a second questionnaire in January 1998 for your approval.

I can assure you of your anonymity, that all the details you give me will be kept strictly confidential and that I sought permission from ... Dean of School to approach you.

I hope you agree that the information gained will not only be useful to nurse lecturers in Higher Education but also to all nurses in both the teaching and delivery of nursing. I would therefore very much appreciate your help in responding to the draft questionnaires and helping me finalise the tool.

If you are unsure about any of the questions or require additional information about the project please do not hesitate to contact me at the above telephone number.

Thanking you in anticipation

Best wishes
Jane Coad

Appendix 13b

Feedback sheet used for the test-retest of the questionnaire

1. How many minutes did the questionnaire take to complete?

2. Did you understand the instructions on the first page ? Is there anything that you would like to see added?

3. Were the instructions clear for **each** of the **8** stem questions? Is there anything that you would like to see added?

4. Were questions 1 – 6 clear?

5. Were the scales used in question 7 clear?

6. Were the statements in question 7 clear? Were there any that you feel were unclear?

7. Were the satisfaction / importance scales used in question 8 clear?

8. Were the statements in question 8 clear? Were there any that you feel were unclear?

Was there anything else you want to add about the questionnaire?

Thank you for your help in this process.

Appendix 14

Coding using categories generated from Miles and Huberman (1994)

'Start list' coding using three digit key letters at Stage 1

Category Start List	Digit master code
1. Career	CAR
2. Current job title (Actual and preferred)	CJT
3. Current role attributes	CRA
4. Future role attributes	FRA
5. Current cultural and organisational understanding	COU
6. Future cultural and organisational understanding	FOU
7. Organisational Merger Preparation	OMP
9. Personal Merger Preparation	PMP
10. Benefits of role in Higher Education	BHE
9. Problematic issues of role in Higher Education	PHE

Appendix 15

Digit Code list from interview transcripts

Master Code	Category	Internal Code
CAR	**= Biographical / Nurse education career background Qualifications / Career Plan**	
	Self Development	CAR-SELFD
	Academic challenge	CAR-ACDCC
	Role model	CAR-RMODL
	Enjoyed teaching	CAR-ENJOY
	Convenience	CAR-CONVN
	Advised	CAR-ADVSE
	Nursing speciality	CAR-NSPEC
	Higher Degree	CAR-DEGRE
	Teaching qualifications	CAR-TQUAL
	Research projects	CAR-RESCH
	Contract/pay	CAR-COPAY
CJT	**Current Job title**	
	Nurse Teacher	CJT-NTECC
	Nurse Tutor	CJT-NTURC
	Nurse Lecturer	CJT-NLCRC
	Senior Lecturer	CJT-SLCRC
	Unsure	CJT-UNSRC
	Preferred job title used	
	Nurse Teacher	CJT-NTECP
	Nurse Tutor	CJT-NTURP
	Nurse Lecturer	CJT-NLCRP
	Senior Lecturer	CJT-SLCRP
	Name	CJT-NAMEP
	Other	CJT-OTHRP
CRA	**Current Role Attributes**	
	Nursing expertise	CRA-NXPTS
	Academic expertise	CRA-AXPTS
	Theory/Practice skills	CRA-TPSKS
	Clinical credibility	CRA-CREDI
	Administration	CRA-MANAD
	Develop students	CRA-DEVST
	Teaching skills	CRA-TCHSK
	Adaptation skills	CRA-WITHT
	Questioning attitudes	CRA-QUEST
	Autonomy	CRA-AUTOY
	Communication skills	CRA-COMMS
	Role model	CRA-RMODS
	Motivation	CRA-MOTVT

APPENDIX 15 continued

Master Code	Category	Internal code
FRA	**Future role attributes**	
	Nursing expertise	FRA-NXPTS
	Academic qualifications	FRA-AQUAL
	Theory/practice skills	FRA-TPSKS
	Teaching skills	FRA-TEACH
	Communication skills	FRA-COMMS
	Autonomy	FRA-AUTOY
	Networking opportunities	FRA-NETWK
	Wider culture	FRA-WIDEC
	Adaptation skills	FRA-ADAPT
	Research & Publishing	FRA-RESCH
	Unsure	FRA-UNSUR
COU	**Current Cultural and Organizational understanding**	
	Rules	COU-RULES
	Communication	COU-COMMS
	Management	COU-MANGE
	Work organisation	COU-WORKO
	Curriculum developments	COU-CURRC
	Work organisation	COU-WORKO
	Unsure	COU-UNSUR
FOU	**Future Cultural and Organizational understanding**	
	Rules	FOU-RULES
	Politics	FOU-POLTC
	Management	FOU-MANGE
	Curriculum	FOU-CURRC
	Teaching delivery	FOU-TEACH
	Student issues	FOU-STDTS
	Research/Publishing	FOU-RESCH
	Academic issues	FOU-ACISS
	Clinical issues	FOU-CLINI
	Unsure	FOU-UNSR

Appendix 15 continued

Master Code	Category	Internal Code
OMP	**Organizational Merger Preparation**	
	Study days/courses	OMP-STUDY
	Formal meetings	OMP-FORMT
	Informal meetings	OMP-INFMT
	Correspondence	OMP-CORSP
	Published literature	OMP-PBLIT
PMP	**Personal Merger Preparation**	
	Communication networks	PMP-COMNT
	Published literature	PMP-PBLIT
	Experience	PMP-XPREN
	Academic experience	PMP-ACDMX
	Research project	PMP-RESCH
BHE	**Benefits in Higher Education**	
	Academic	BHE-ACDMC
	Nursing	BHE-NURSG
	Theory/practice	BHE-TPSKL
	Role clarity	BHE-ROLES
	Research	BHE-RESCH
	Self development/Career	BHE-SELDV
	Status/contract	BHE-STSCO
	Unsure	BHE-UNSRE
PHE	**Problematic issues in HE**	
	Nursing skills	PHE-NSKLS
	Teaching issues	PHE-TEACH
	Theory/practice	PHE-TPSKL
	Bureaucracy/Organisational	PHE-ORGNL
	Responsibilities/Workload	PHE-RESWK
	Role uncertainty	PHE-RLUNC
	Support issues	PHE-SUPRT
	Stress	PHE-STRES

Appendix 16a

Tel 331 6161

Dear,

Thank you for the discussion on the telephone today and for agreeing to see me next Wednesday in relation to my research investigation as part of my MPhil/Phd programme. I would now like to ask permission to interview a group of fifteen staff who will transfer from the college into the university.

My investigation aims to examine the impact on nurse teachers role as a result of the merger of nurse education into higher education. I have enclosed the aims and an outline of the project. It will involve interviewing the staff three time over fifteen months. It is hoped that through examining such issues the study will explore the relationship between the theory and practice of nursing and will have implications for all those involved in nurse education. I have enclosed with this letter an outline of my objectives and the completed forms that you sent me.

I have also enclosed with this letter the required forms from the University of Wolverhampton for this. I believe the university ethics committee, which you chair, meets next Monday and I wondered of this could be discussed at that time. I hope approval can be given to complete the work.

Please do not hesitate to contact me should you require additional details.
Thanking you.

Regards

Jane Coad
Senior Lecturer

Appendix 16b

Letter to the hospital/ward manager about the interviews at Stage 3

Dear

I would now like to ask permission to interview some of your staff as part of my investigation which aims to examine the impact on nurse teachers role as a result of the merger of nurse education into higher education. I have enclosed the aims and an outline with this letter to help you. It is hoped that through examining such issues the study will explore the relationship between the theory and practice of nursing and will have implications for us all. I have enclosed in this letter an outline of my objectives to help you but please do not hesitate to contact me should you require additional details.

In relation to specific details I will need to interview at least five qualified nurses who have been registered for at least one year. I am also enclosing some suggested dates below when I could come to the ward to conduct the interviews, which will be of a semi-structured format and will last no more than 45 minutes per person. I can assure you and your staff that the ward and all the details will remain strictly confidential.

Please let me know if any of the dates are convenient to you and your staff. My telephone number is at the right hand top of this letter and I shall look forward to hearing from you. Thanking you for all your help and support.

Kind regards

Jane Coad
Senior Lecturer

Suggested dates:
30th. April from 10.00 hours to 15.00 hours
6th. May from 10.00 hours to 15.30 hours
13th. May from 10.00 hours to 15.30 hours
15th. May from 12.00 hours to 15.00 hours

Appendix 16c

Letter to the clinical staff interviewed at Stage 3

Ward X
To whom it may concern

Having secured an invitation via your Hospital and Ward Manager for you to be interviewed, I would like to thank you for offering to participate in my study. The focus of my study is to explore the impact of the merger into higher education on the nurse teachers role, which has involved me to date interviewing a group of nurse teachers as the transfer occurred. I have enclosed the aims and an outline with this letter to help you.

I would very much now like to interview a group of clinical nurses in adult, paediatric and mental health settings to examine the impact of this merger from their perspective. For additional interest I have enclosed an outline of my objectives of this study for you.

In relation to the specific details I will be using a semi-structured interview format which will last no more than 45 minutes. I will give you an outline of that schedule before the interview takes place. If at any point you do not understand the questions please tell me or if you feel you can not answer any specific question or even wish to discontinue the interview you will be more than welcome to.

I can also assure you and your ward of anonymity and that all the details of the interview will remain strictly confidential. Once typed I will send the interview transcript for your approval and will send you a final report of the study.

Thanking you for all your help in agreeing to be interviewed as part of my study. My telephone number is at the right hand top of this letter and I shall look forward to hearing from you.

Kind regards

Jane Coad
Senior Lecturer

Suggested dates:
30th. April from 10.00 hours to 15.00 hours
6th. May from 10.00 hours to 15.30 hours
13th. May from 10.00 hours to 15.30 hours
15th. May from 12.00 hours to 15.00 hours

Appendix 17

Newsletter to interviewees (example from Stage 2b)

Dear

Thank you once again for letting me interview you at this stage (Stage 2b). I am enclosing the transcript of you last interview. Do read it through and let me know if you have any amendments or additions that you wish me to make to it. If I do not hear from you in two weeks I will assume that you feel the transcript s a fair record of the interview.

As promised, I am also enclosing the 'news' from my data analysis to date. I will send you another letter in six months following data analysis of this stage but do not hesitate to ring me should you wish.

NEWS!

Thank you to you all for your information at Stage 2a. I have analysed all 15 of your transcripts. The emerging data seems to be falling into two big issues the first being organisational and the second being the actual role that you do.
One thing that comes out is that you all knew the college well including the formal and informal rules. The merger into University A was not a concern to you all at this stage. You all told me the merger would be good for nursing however traumatic it might be!

The nurse teacher role is indeed complex and it has been a challenge to 'map' out the picture. I have put the role attributes into classroom, student, clinical, managerial /administration, personal and future. I hope you approve!

Once again thank you so much for being involved in my study and being as enthusiastic as me about it!
I will see you for interview three at Stage 2c in twelve months time!

Best wishes

Jane

Appendix 18a

Development of interview schedule from key concepts at Stage 1

Initial responses from the interviews
(Prior to coding)

Nurse Teacher
Nurse Tutor
Nurse Lecturer
Name of nurse teacher (First name / surname)
Career choices –
Challenge
self development
personal choice
convenience
advised

Nursing speciality
Nursing experience
Expertise (Nursing / Academic)
Academic issues (Academic / Higher Degree)
Enjoyed teaching
Preparation for role
Teaching qualifications and skills

Classroom
Clinical
Development of students
Support/help
Theory/Practice ;
Classroom role
Clinical role
Attitudes to theory /practice link
Role in theory and practice link (Visits)
Personal Clinical credibility

Personal attributes
Organised
Positive Role model
Change agent
Facilitation
Questioning
Autonomy /Self Management
Communicator
Hard working
Networking opportunities
Motivation
Adaptability
Management

Curricular development
Organisation / culture of work
Academic issues
Clinical issues
Communication networks
Politics

Appendix 18a continued

Management
Administration
Resources
Curriculum
Teaching delivery
Bureaucracy/Organisation
Work responsibilities
Educational developments

Student issues
Study days/courses
Formal meetings
Informal meetings
Formal rules
Informal rules
Marking of work
Supervision of students
Correspondence
Publication / research expectancy
Communication networks
Team work
Role clarity
Role understanding
Role conflicts
Role uncertainty
Role opportunities
Support issues
Stress

Nursing profession effects
Nursing Care issues
Research issues
Studying and personal development
Recruitment
Retention

(n = 75 categories of key phrases from the discussion)

Appendix 18b

Following Stage 1 interviews - Putting the responses into categories (2nd review)

Current Job Title/preferred

Nurse Teacher
Nurse Tutor
Nurse Lecturer
Senior Lecturer
First name
Name of nurse teacher
Unsure of title (n= 7 emerged areas)

Career plan of nurse teachers

Nursing speciality
Self Development
Academic challenge
Teaching qualifications
Role model
Research
Enjoyed teaching/choice
Convenience
Advised (n= 9 areas of discussion)

Nurse teacher attributes (Current and Future)

Nursing speciality/expertise
Academic / Higher Degree /skills
Theory/Practice Skills
Teaching qualifications
Student development/counselling
Research & Publishing
Personality Communications
(Colleagues, Clinical staff, Students, Senior managers)
Adaptation
Questioning
Autonomy
Wider networking opportunities
Role Model
Motivated
Supportive/help
Contract/ work conditions
Self Management

Organisational management
Administration
Bureaucracy/Organisation
Marking
Meetings

(n = **5** broad areas emerged = Classroom, clinical, student, personal, managerial)

Appendix 18b continued

Cultural and Organisational understanding

Rules
Politics/communication
Meetings (Formal and informal)
Communication networks and 'team' work
Management/Bureaucracy
Administration
Curriculum
Teaching delivery
Educational developments
Student issues
Research/Publishing
Academic support (Courses and study days)
Clinical issues
Unsure

(n = 14 emerged concepts; 4 areas of - rules, work organisation, curricular, communication)

Merger Preparation and knowledge (Organisational and personal)

Study days/courses
Formal meetings
Informal meetings
Correspondence
Published literature
Communication networks
Published literature
Experience
Academic experience (n = 9 emerged concepts)

Issues in Higher Education (Benefits and problems)

Academic
Nursing
Theory/practice
Role clarity
Research
Self development/Career
Cultural rules (Formal / informal)
Nursing skills
Teaching issues
Theory/practice
Bureaucracy/Organisation
Responsibilities/Workload
Role uncertainty
Support network issues
Stress (n = 15 emerged issues)

Appendix 19

Shortened extracts of interview transcripts from Stages 2a, 2b, and 2c

SEMI-STRUCTURED INTERVIEW FRAMEWORK
NURSE TEACHERS

Interviewee 2a.10
Stage 2a - Prior to merger

1. Age group? Background information?
Nurse teacher - 3 years. 39 years. F. Ward link (adult based) x 5

2. What is your current job title? What is your preferred title?
Nurse Tutor. I prefer students to call me by my first name and on the wards. On the phone as an introduction I say Nurse Tutor.

3. Why did you choose nurse education as a career?
Prompt : Career path do date
Speciality chosen

Well, it all just seemed to be right... in my career plan and there was the opportunity. I was asked by a Nurse Tutor. I wanted to be a positive role model and I like education as well.
But mostly I wanted to link theory to practice and vice-versa.

4. Can you tell me your qualifications? / Qualifications since last interview?
Prompt : Nursing qualifications/experience
Academic qualifications/skills
Personal

RGN. Just completed my BSc. degree -"felt pressure to do it".
5 years experience before I came into education – was a Ward Sister before entering

5. Can you tell me your current role attributes which you possess?
Prompt : Classroom
Students
Clinical
Managerial/Administration
Personal

1. Being a nurse - you could not do the teaching if you weren't
2. Developing the professional base to nursing so that's students
3. Autonomous ... I just get on with the job but need to communicate with friends at work and managers. And clinical staff .. and students .. them all !

I feel that the most valuable aspect ids the nursing without a doubt (need the nursing experience to do job). The worst aspect is getting out on wards – so I feel we should but very difficult. At least we do have named links so they know me even though I only visit or phone call but time is our greatest problem – time to do it all I mean.

6. What is your understanding of the culture/organisation of the college/university?

Prompt : Philosophy
Rules
Hierarchy
Strategies of management
Organisation of work
Communication pathways
Curricular Delivery & developments

Well it's very stable! Is hierarchical system I suppose of secretaries, teaching and management – we know what we are doing. Feel this merger will hit us hard because of that.
Strong emphasis on clinical links which is good – work in teams
Academic development of staff is clearly defined as well.
Not perfect as lots of rules and managers but "college feels like a pair of old slippers"

7. What do you think this merger will mean (has meant) to nursing education and training?

Prompt : 3 positive
3 problematic

Positive : *Push profession into change*
Higher academic emphasis
More research driven

Problems: *The higher academic emphasis will be a problem for some*
I think it will be stressful – I am not really sure actually but am guessing that one
I think there will be a greater loss of clinical nursing skills – it's a different place with different values to nursing that we know.

8. What organisational preparation have you had (or did you have) for the
Very little actually – one formal college meetings organised. Attended 1 union meeting. Have had some memos from the college but none from university

9. What personal preparation have you had (did you have) for the merger into higher education?

Prompt: Personal strategies employed

Contacts
Adaptation to rules
Status
Promotion

We have had team meetings but none of us really know .. tends to be 3rd hand!
A lot of informal discussion mostly on the grapevine
Also, just a point ... I have found little literature around to read,

10. What do you feel will be your future role attributes within higher education? How will your role develop in the future?

Prompts : Change envisaged
Strengthening of role
Classroom
Students
Clinical
Managerial/Administration
Personal

Unsure really - unsure if I'll even survive! We have been told that we have to interviewed for our jobs – which is abit insulting. Don't know what the job will be or what we will called or anything.

But, I hope it will be more student centred.
More self autonomy. More self- development opportunities such as research.
Not so hierarchical structure but really unsure

11. Can you give me three benefits of your role (perceive or actual) from working in higher educational?

More parity as used to have 'cross college' issues - better for clinical areas
Self Development
Improve profession of nursing

12. Can you give me three problematic issues of your role (perceive or actual) from working in higher education?

Unclear right now and uncertain about my role.
Need to look wider afield at other systems and use their experience to help steer.
Starting to feel anxious – I think that it will be more demanding and higher stress. There might be a higher demand on teachers due to flattened structure

Examples of data analysis process of the interview transcripts of Stages 2a,2b and 2c

Stage 2a

Questions used 1,2, 3 & 4

CAR 13 entered as unqualified nurse teachers
11 stated they were NTURC/ 4 NTECC (2 emphasised specialism)
0 UNSURE or other categories

All 15 with their nursing and teaching qualifications at first interview
All 15 unsure of proposed title in higher education

All 15 in nurse education at least two years/13 as nurse teacher
Qual teacher role x 13
Choose education due to
SELFD x 12
RMODL x 9 (positive)
ENJOY x 10
CONVN x 3
ADVSE x 5 (senior nurse x 2 / nurse teacher x 3)
COPAY X 2

(Quotes P7 stretch self, P4 academic challenge & P8, P9advised)

Experience - General/adult x 10 Specialists referred to by self x 3
Mental Health x 3
Paediatrics x 2
(Senior positions/leadership x 3)
All had been in nursing at least years in service **P4** (including nursing education).

NSPEC - 13 felt nursing of greater importance than academic
DEGRE - x13 had existing first degree (2 started)(1 just finished **P9**)
x 6 registered/intending to register for higher degree
x 8 stated degree undertaken due to academic change/pressure **P10**
TQUAL - no response re: teaching qual as high as academic or nursing
2 stated of little use in day to day role (Quotes **P14, P5**)
Teaching 'ologies' x 6 (3 felt impact on career) **P10****
RESCH - x1 undertaking independent research project
x 3 undertaking research projects as part of 1st/higher degree

Appendix 19 continued

CJT NTECP X 4
NTURP X 11

CRA - NXPTS essential to perform role x 14- **P8, P12**
(Clinical credibility)
AXPTS useful to perform classroom role x 11
TPSKS - x 9 in classroom / 12 in clinical
4 were on named links on ward which they felt unqualified to be on
DEVST x 15
TCHSK x 10 - x 3 included a range of activities
WITHT x 3
(quotes from P1, P2, P12, P15, //// P6, P3, P8, P15)
Questioning attitude x 2 (Relate to personality)
AUTOY – x 2 **(P5 quote as specialist)**
COMMS- x 14 stated essential attribute with colleagues
(Also relate to personality)
COMMS x 14 with senior manager
COMMS x 15 with students
Support x 2
Positive RMODS x 6
MOTVT Hard working x 4
Experience x 1 but overlapped into NEXP/AEXP/ADAPT
Research x 2 mentioned
ADMIN x 9

Most valuable attribute - Nursing x 9 **P9, P10**
Personality traits x 4 + self awareness **(P6), (P14)**
Credibility x 2 + good quality courses mentioned
Theory/practice links x 1
Specialist in a non- specialist world x 1

Worst attributes of role - Time x 6 **P9, P10**
Diversity x 1 **(P1)**
Organisation x 1 **P11**
Commitments x 2 **P12**
Up to date x 3
Responsibility x 2 (Total = 15)

FRA NXPTS - 4 stated that this would be lost
Loss of specialism cited x 2 (more specialism x1)
Clinical role loss x 2
TPSKS x 3
Clinical role change would be radical x 1 **(P3** quote)
UNSUR x 4 **(P11, P10, P3 & P15 quotes)**
AQUAL - More emphasis x 13 **P1, P5**
TEACH x 4
RESCH x 6 More research x 1 **P5**

Publish more x 2
AUTOY x 1 felt that the culture of higher education would encourage more autonomy in workplace
NETWK x 3
ADAPT x 2

Quotes - 'Less Jack of all trades' x 1
No change x 1. UNSUR x 4 **P3, P11**

COU RULES x 12 (Formal and informal) (2 felt *inflexible* **P3, P10)**
WORKO x 12 - Hierarchy structure **cited by 9 P1, P4 (Safe), P9**
(Stable – *feels like old slippers*!) **P14, P15**
MANGE x 8 - Shared project teams x 3. Delineated teams. *Work together to link T/P* **P15.** 5 problem in this
CURRC x 8
Central power but feel involved x 1 **P2**
Worked together on mutual trust x 4 **P1**
Friendly x 2
CUMMS x 12

(Quotes *'Proud to work for college'* **x 1, P4)**
Colleague issues included safety and friendly, trust x 13
UNSUR x 0

FOU

ACISS x 13
RULS x 8 Different flexibility ...**P2,** more 'ology' driven **P1,** less rules, more autonomy
POLTC x 1 Pathways more open ...**P4**
MANGE x 4
More bums on seats ...**P11** Less caring; more DIY ..Larger intakes - very worrying ... **P1** More autonomy **P4, P8**
CURRC x 2 More ology driven ... **P1, P8**
TEACH x 4 - different staff expectations **P5**
COLLEAGUE ISS x 8
STDTS x 6 More flexible **P2**
Student centred **P6, P9**
Bigger groups, More student centred facilities
RESCH x 6 'Different philosophy in that research / academic emphasis will play a larger role - must inevitably impact on role and teachers' .. **P5**
CLINI x 4 - Interesting to note *
UNSUR x 4 **(P12, P14)**

Additional = T/P = 3, networking x 3, adaptation x 2 and autonomy x 1

Appendix 19 continued

OMP

STUDY x 0 Attend another university .. **P2**
FORMT x 4
(Union, College, University x 1) *Take over not a merger* **P14**
(*Very little!* **P3, P1** – *monster in wait!)*
Informal – FORMT x 15 (Grapevine in all transcripts!)
CORSP x 15 from college / 0 from University (Circulated memos but largely from college)
Published lit x 2
Nothing x 0

PMP

COMNT x 15 Those I trust ...**P11.** Direct = 5 (Union). X 2 with existing university staff.
(Talking to friend/colleagues high x 15/ Gossip high **P8**)
XPREN x 4 (*Written modules already* x *1). (*RESCH x 2)
Several expressed doubt at this time x 8 re PMP & own knowledge of higher education infra-structures

BHE

ACDMC x 6 - *Wider choice x 7, Resources x 2*
SELDV x 9 *(Career* **P4**, *Educational opportunities x 2, Kudos x 6)*
NURSG x 15 - *As a profession ... shift out dead wood* ...**P6**
TP x 1 *positive More parity as share across area more not separate colleges ...* **P4** *never thought this would happen* ...**P10**
Role Clarity x 3 more defined role **P7, P8**
Teaching issues x 4
RESCH x 6
UNSUR x 0 *(***P12** *added that could not think of three!)*
STSCO x 9

PHE

NSKLS x 15 - *Clinical expertise lost* .. **P1**
TEACH x 13 - More student / staff ratios **P15**
Bums on seats **P11**
Might be a more open system which could go either way .. **P6**
TPSKL x 9 Theory –practice x 9 expressed concern about traditional link roles and values being different
ORGNL x 7 Increased workload **P3,P5,P6**
RESWK x 4 Values different to ours ... **P3**
RLUNC x 2
SUPRT x 4 Learn to fight more **P8**
STRES x 7 **P9** - Bigger groups/increased wastage x 8
Loss of role identity x 1
Greater demand on individual nurse tutors potentially
P9 P10,P1 = greater stress
On own more **P13 quote.** Needs collaboration

Shortened extracts of the interview transcripts of Stages 2a,2b and 2c continued

Interviewee 2b.3
Stage 2b – At the merger

1. **Age group? Background information?**
   Nurse lecturer "Waiting to find out"

2. **What is your current job title? What is your preferred title?**
   Well quite positive - feel it will be good for profession in the long run but feel anxious about the logistics at the moment

3. **Nurse education career?**
   Well since last time you came .. I am teaching the same really .. level 1 work .. pre registration.. Have thought about developing a specialist area which some nurse teachers are doing.

4. **Can you tell me your qualifications? / Qualifications since last interview?**
   Prompt : Nursing qualifications/experience
   Academic qualifications/skills
   Personal
   No change actually. I am also thinking I should register for my Masters .. I have got course programmes and may do it here but I feel that's this is something that will be valued.

5. **Can you tell me your current role attributes which you possess?**

1. Nursing experience and some academic. So linking theory to practice...
2. Personality (enjoy students development in class and per say) and resilience ...I have to communicate with colleagues, senior staff and students right now .. this is important
3.We all feel we are waiting for this merger to happen – there's a kind of wait and see policy – its unspoken but its definitely going on so administration is low on the priority list right now I feel

Worst attribute? *Clinical update*
Important ? *Communication*

6. **What is your understanding of the culture/organisation of the university?**

Prompt : Philosophy

Unsure – 'I actually have no idea what it will be like – the rules are unclear about it all – I am even unsure who everyone is even after the induction day - we

have had some preliminary information but actually no-one has informed us of the expected role – my worry is we will be expected to make it up as we go along ... and seems to have very different curricular delivery such as modular, wider choice and larger groups.

7. What do you think this merger will mean (has meant) to nursing education and training?

Prompt : 3 positive
3 problematic

Positive: *Improve professional emphasis for all nurses*
Problems: *Feel very concerned that we may lose out to who people are out there in practice*

8. What organisational preparation have you had (or did you have) for the merger into higher education?

Prompt: Organisational strategies employed
University arrangements
Status
Promotion

A very 'odd' i*nduction programme - not really that helpful as they rather told us what we would doing rather than the other way round (considering the huge*
business we will bring!) but in fairness some individuals were better than others

9. What personal preparation have you had (did you have) for the merger into higher education?

Prompt: Personal strategies employed
Contacts
Adaptation to rules
Status
Promotion

Own experience to date really - Discussion with colleagues – some literature

10. What do you feel will be your future role attributes within higher education? How will your role develop in the future?

Prompts : Change envisaged
Strengthening of role
Classroom
Students
Clinical

I think more teaching of "ologies" - now feel less individualism in a way. "Old" contacts could be torn as we move away from college sites

Actually unsure as to role because we feel to date we have been told about university but little asked about us and own needs

11. Can you give me three benefits of your role (perceive or actual) from working in higher educational?

1. *Academic development*
2. *Kudos - More career development and professionalisation for all nurses*
3. *I think it will push us along – I hope – more research opportunities for example*

12. Can you give me three problematic issues of your role (perceive or actual) from working in higher education?

1.Communication is getting worse – so I feel more segregated , feel very isolated and devalued. Very few people actually speak out - myself I do try but I feel I shall be labelled soon for this!

2.Chipping away of skills and nursing as we know it. Possible devalue of degree - as more nurses do then how can we ensure parity and standards so as result the fragmentation of nursing

3.Feel some days positive and other not sure if I want to work in this new world but I'm sure I'll have to because I need the money!

Appendix 19 continued

Examples of data analysis process of the interview transcripts of Stages 2a,2b and 2c

Stage 2b – At the merger point

CJT

NTECC x 1
NTURC x 8
SLCRC x 2
UNSRC x 4
All said 'confusion' over titles (15)
Quotes - *Waiting to find out !* **A2/** *Feel abit insulting* **A 13, A3**
Several stated (x 7) issues relating to confusion of job titles & decisions left outstanding. **A8** *re; unsettling /* **A15** *very anxious.. very unsure what I am and disappointed. Up in air* **A6.**

Other feelings included increased anxiety (8) Uncertainty.
Prove self (5)
Powerlessness (4)

CRA

NXPTS x 12
(Clinical credibility)
AXPTS useful to perform classroom role x 15
A12, A14 quote re academic development
TPSKS - x 7 in classroom / 9 in clinical
DEVST x 15
TCHSK x 8
WITHT x 12
(quotes from A2, A9,A5, A7, A14, A10, 14)
Questioning attitude x 2 (Relate to personality) **(A1), A5**
AUTOY – x 3
COMMS- x 15 stated essential attribute with colleagues
(Also relate to personality)
COMMS x 15 with senior manager
COMMS x 15 with students
Positive RMODS x 10
MOTVT Hard working x 4
Research NOT mentioned
ADMIN x 7
Support issues quote **A1**
Wait and see policy **A3**

FRA

NXPTS x 5
ACISS x 14 (Up from prior group ***) **A4** *(Same old job!)*
RESCH x 9 (Up x 3)
TPSKS x 4
ADAPT x 5
AUTOY x 10 (Up x 13)

x 9 referred to changes envisaged e.g. large groups)
COMM x 0
MOT x 0
NETW x 7(up x 4) **A6**
UNSUR x 9 **A3, A6, A9, A14**
More teaching x 4 (x1 felt more Nurse teaching **A7**)

COU

RULES x 14 *Find out rules as we go* **A15,A2,A7,A14**
ATTUD x 12 (up x 3 - quotes **A5 / A8** re change of attitude)
COMM x 15
MANGE x 4 (Work organisation unsure/unclear)
('Getting much worse - we need to get better at this
or we will really lose out **A2 / A4/ A10/ A9**)*Autonomy* = **A10**
CURRC x 13
TEACH x 2

Formal day but still unclear **A4**
Difficult time **A8**
Culture – rock the boat – **A15**
New delivery .. new model **A13**

FOU

RULS x 4 More flexible / More flattened A1
POLTC x 7 Spread out as a group **A9, A5**
MANGE x 6
More self reliant = much change. Feel that this will take me away from clinical role even more **A8**
CURRC x 1 **A6**
TEACH x 3 Greater demands **A1**
STDTS x 2
RESCH x 2 More encouraged to develop
ACISS x 1 Pressure to perform **A12**
CLNIS x 2 Appears to be much lower on agenda
UNSUR x

Feel like to date we have been told about the university but little asked about us **A5**
Uncertain x 6 - Anxiety x 9 - Excited x2
Unclear about culture yet as not learned the rules! **A10**
Grieving for those left **A1**
Loss of control **A11**
Very worried as to my future **A4**

OMP

STUDY x 15 (all attended welcome day)
FORMT x 15 (Union + Old college + University)

INFMT x 10
CORSP x 15 (College Circulars) (University x 4)
PBLIT x 1 (strange but little around to read from university about culture & organisation although lots of memos)

x 8 referred to take over philosophy
x 4 felt unwelcome **A1, A6 A11, A3**
x 3 moved location so felt university change **A1, A5, A11**
x 9 no job contracts so increased anxiety
x 2 felt positive about merger even though anxious

PMP

COMNT x 15 *(Old colleagues especially drawn upon* - **A9, A6)**
Union representation x 11 (Excellent)
COMNT x 1 (University staff)
PBLIT x 9
XPREN x 4
ACDMX x 0
RESCH x 0

BHE

ACDMC x 6 **A7,** 'Develop us all as a profession' **A11**
NURSG x 14
TPSKL x 1 Less **A13**
ROLES x 1 **A6**
RESCH x 10 'Publish or perish!' **A6, A3**
SELDV x 9
STSCO
UNSUR x 0
AUTOY x 1 **A10**
NETWORKING FACILTIES x 9 **(A10, A14)**
INCREASED STATUS x 13 (**A13) *****
INCREASED PROFESSIONALISM X 14 ******
Organisational x 2
Structure **A1**

PHE

NSKLS x 14 Less skills to go out there **A10, A15, A13**
TEACH x 10 Large groups - **A7, A8, A12, A9**
TPSKL x 9 TP gap increase **A7, A8**
ORGNL x 7 **A5**
RESWK x 1 **A4** (Increased pressure from RESWK = 3)
SUPRT x 2 Less secretarial support x 1 **A6, A8**
STRES x 6 More demand on self **A3, A2**
RLUNC INCREASED ANXIETY X 14
Flattened hierarchy = increased perceived stress A5
A7, A11, A14 - *Next 5 years turmoil*
X 5 = Marginalisation

Shortened extracts of the interview transcripts of Stages 2a,2b and 2c continued

SEMI-STRUCTURED INTERVIEW FRAMEWORK
NURSE TEACHERS Stages 2a, 2b and 2c

Interviewee 2c.11
Stage 2c - After merger

1. Age group? Background information?
Experienced as a nurse and as a tutor - glad this was acknowledged by university. Credible to perform role / Academic-nursing experience (worry about those who do not have enough nursing experience and enters education now)

2. What is your current job title? What is your preferred title?
Principal lecturer now - put this on all my letters but tend not to use face to face with clinical staff

4. Nurse education as a career?/ Career path do date
Now teaching level 2 and degree work – organise a team of people to deliver post-registration programmes. Supervision of Research dissertations.

4. Can you tell me your qualifications? / Qualifications since last interview?

Prompt : Nursing qualifications/experience
Academic qualifications/skills
Personal

Yes – pleased to say I have finished my Masters degree – felt I needed it for all sorts of reasons!

5. Can you tell me your current role attributes which you possess?
1. *Developing the students and working alongside them and the team.*
2. *I do a lot of administration now that secretaries should do – I resent that. I feel its abit like the ward sister in that the most qualified nurse is in the office ... and not that I am the most qualified person here but I do spend a lot of wasted time I feel on admin/meetings and letters. I do like to talk and help students and the staff in my team but how can I? I often work late and still never it ends!*
3. *Feel that I have adapted well – I have got more experience now and academic qualifications and I am (most days) positive about it all now which I wasn't when you last came.*
4. *I do lots of networking now in the university but wider afield – you have to as its really what you make of the job. So I manage, teach, liase and network*
5. *My problem is although I am the route director I am not really the 'teams manager'... staff are not accountable to me but come to me all the time ...*

Sometimes I have meeting and fewer people turn up – they all seem to be doing their own thing these days

How develop role?
Need to get into networking and liasing more than we do.
Need to use academic opportunities we are being given
Stay positive and motivated I think.

6. What is your understanding of the culture/organisation of the college/university?

Management - quite a shift for college staff and for university too I think as well as having us move in as a group. I'm still not sure that they'd have chosen us all but they are stuck with us now! Lots of planning and quality initiatives as well. Much more pressures to deliver.

There are clear schools actually but still unsure of some of senior positions or even who they are (not in nursing I mean but in the university per say) University takes a while to get to grips with individuals and process - I have made a few errors just because I did not know the management process and I'm very careful who I say what to. Never felt like that in college too much

I would also say I have developed a hard shell! Seriously, became my own agent and worked hard to be seen as credible and worthy of the post and responsibility given Its very subtle how the university takes you over but sometimes I wonder if we are still perceived as the ex-nurse tutors by those here in university and clinical areas

Best : *Initially I would answer increased academic face of nursing which we needed ie: wider arena / Supernumerary status - wonderful to develop theoretical aspects of students but there is a downside to this / Set new standards for us - demanding to meet them but useful*

Worst: *Sometimes worry about workloads *large groups does not equate with expectation * large groups could result in less supervision and support = less able * large groups could mean less practical experience so when they qualify not as adept. Also supernumerary status such a problem in ensuring full development of nursing skills .. so many demands on us I think*

7. What do you think this merger will mean (has meant) to nursing education and training?

Better academic qualifications – no doubt there and wider cultural awareness in nursing and the university higher education systems.
Personally, I am as I say more autonomous and made more contacts – that can only be good for nursing in the end.

8. What organisational preparation have you had (or did you have) for the merger into higher education?

Abit odd if I am honest. You know we had the induction day – not a huge success – well after that we just moved in – I thought we might get a welcome party but no – we just moved in and got on with it! This is a problem because a lot of people don't really feel that they have transferred (I worry about that).

But now I have been to lots of meetings and I have picked it up as I go along .. the emails and university paper is great in one sense as you learn a lot but in another its yet another demand! I also went the other day to a study day about publishing which was lovely because it was cross faculty and there were no nurse teachers there!

9. What personal preparation have you had (did you have) for the merger into higher education?

Communicate with colleagues which due to pressures is getting hard to do. And of course now my own experience – learning as I go along really. I do read journals especially the newspaper (Education Guardian).

10. What do you feel will be your future role attributes within higher education? How will your role develop in the future?

More leadership I should think. I hope it gets clearer and I hope we recruit some staff fairly soon.

11. Can you give me three benefits of your role (perceive or actual) from working in higher educational?

1. *Two worlds together should result in enriched but doesn't feel like that some days. I suppose one benefit is my job contract. Need to demonstrate we are an asset to the university not a headache...and we are an asset!!*
2. *More self development, be creative and resilient. More flexibility in this job so can do it – I like the flattened structure now really.*
3. *Develop nursing through increased academic and professionalisation*

12. Can you give me three problematic issues of your role (perceive or actual) from working in higher education?

1. *I was never good at this but it has to be the loss of clinical skills. I feel we have sold out and I think our teaching will suffer as a result (Theory /practice gap will get wider)*
2. *It is isolating although I like the autonomy – sound like that's a contradiction but they come hand in hand. Think we should develop more sharing as a school.*
3. *Increased my role three fold – sorry but it has.*

Appendix 19 continued

Examples of data analysis process of the interview transcripts of Stages 2a,2b and 2c

Stage 2c - After merger point

CJT - NTECC x 0
NTURC x 0
NLCRC x 1
SLCRP x 14
PLCRP x 1
UNSUR x 0

quotes - **AFT 1, AFT2, AFT3** (contract only), **AFT7, AFT9, AFT13, AFT15**
Related to title on contract being different to that used on telephone
10 on phone stated Nurse lecturer or Nurse tutor **(AF1, AF9)**
5 – first name

CRA NXPTS x 11 **AFT8, AFT9**
AXPTS x 15 **AF 2, AFT6** to increase confidence **AFT1**
TPSKS x 14 **AFT4, AFT11** - Classroom
TPSKS x 4 **AFT10, AF15** – Clinical **AF8, AF4**
(Clinical credibility x 5), **AF7**
WITHT x 12
QUEST x 3
MANAD x 15 **AF6, AF12, AF10**
AUTO x 9 **AFT2, AFT8**
COMMS x 6/colleagues; COMMS x 10 students;
COMMS x 6 clinical staff; COMMS x 6 senior managers
MOTVT x 6
RMODS x 8 **AFT8, AFT15**
HARD WORKING x 5 **AFT3, AFT4**
New – creativity x 8. **AF6, AF14**

Most valuable role attribute?
AUTOY x 4
PERS +ve x 4 **AFT12, AFT7**
COMM x 1 **AFT15**
NXPTS x 4 **AFT8, AFT11**
ACC + RES x 1 **AFT1, AFT5**
TEACH x 1
NURS x 1

Worst role attribute? More than one now cited .....
Demands x 4
ADMIN x 3 **AFT6, AFT1** (workload)
KEEPING UP TO DATE x 2

TIME x 3 **AFT11**

ISOLATION x 5 (↑ x 5) **AFT5, AFT10**
DEMANDS x 4 (MEETINGS x 3 (↑x 2)
Keeping up to date x 2

Specific responsibilities now cited to test against envisaged future role attributes from previous interviews;

FRA

Quotes – **AF2, AF 9 , AF13, AF12**
NXPTS x 4 MODULAR TEACHING **AFT1,2,4,9,10 & 11**
AQUAL x 15
TPSKS x 10
Ward link/liason issues x 4 (lack of it) **AFT1, 2, 6, & 7**
ADAPT x 13!! Meetings x 1 **AFT1**
AUTOY x 13 Self reliant x 5 (more) **AFT7, 8, 15 + ↑ admin AFT11**
COMMS x 0 ?Comm re T/P issues x 2
NETWK x 11 Specialist issues x 5 **AFT4, 13**
WIDEC x 10 New iniatives x 4 **AFT3**
RESCH x 10 Up to date issues x 4
UNSUR

CCOU

RULS x 14
AFT1, 2, 4, 6 (Q9),7 (Q8) 7 (Q8), 8 (8).
More flexible AFT((8)
COMM x 14 **AFT3 (Q8), 13 (Q8), 15 (Q8 +ve),**
AFT15 (8) =clash of philosophy.
CURRC x 14 More self reliant & autonomy x 2
Very isolated x 6 **AFT1 (8), AFT7 (10)**
Curriculum development work very exciting **AFT9**
Disorganised AFT5 (8 -ve), unsure AFT7 (9), AFT8 (9) AFT2 (9), AFT3 (8), AFT12 (8), AFT12 (5a) *manage self, AFT4, AFT6 (5a +/- ve) AFT6 (8)
MANGE x 0
WORKO x 5
TEACH x 3 **AFT5 (8)**
STDS x 6
AFT11 (5a+/-ve), AFT6 (5a-ve), AFT15 (5a),AFT8 (5a-ve)
RESCH x 3 **AFT7 (5a +ve)**
ACISS x 8 Increased pressure to perform **AFT14 (8), more kudos AFT9 (8), Good resources AFT15 (5a)**
Wider T/P gap **AFT 2 (10)**

FCOU

ACCISS x 10 **AFT5 AFT6, AFT7, AFT9 Comments re: ↑ confidence & professionalism**
RESCH x 6 **AFT4**
CLIN x 9 **Two tiered AFT4. AFT10**
STDS x 5 **AFT3, AFT4, Large groups vs quality**
TEACH x 7 **AFT2, AFT7 (10)+(11), AFT11 (12a)**
MANGE x 3 **AFT1 AFT15, Informal AFT12(9)**
RULES x 2 **AFT1 AFT2**
POLTCS x 6 **AFT11 Speak up more**
CURR x 3 **AFT9**
UNSUR x 0
Difficult year AF15

Increased kudos x 11 noted on separate transcripts mentioned overall e.g. **AFT9(5a)**
Increased pressure noted overall x 4 **AFT7 (5a -ve), AFT9 (5a-ve), AFT13 (5a)**
Communicate better essential AFT4 (11)

OMP

STUDY x 9
AFT13 - need to be better informed, not as organised from AFT15, AFT3 + little as a large group AFT8. More study days have started AFT1, AFT4, AFT12.
FORMT x 15 **AF6**
Lots more x **AFT2, AFT11, AFT14, Informal & formal from AFT5, AFT7, AFT15 - other staff helpful**
INFMT x 15 (See above quotes)
CORSP x 15 Heads especially personal + lots more memos **AFT5, 6 & AFT10**
University magazine cited (14)

No respondent stated that they were now still unclear but several stated wished they had had more as a large group / specific to needs.
Unsure at first for 6/12 but then understood more stated by several **AFT1**

PMP

COMNT x 15 **AF10**
Speciality loss AFT4, AFT15, AFT10, AFT8, AFT9
Networking more essential due to isolation AFT5, AFT12, AFT13
PLIT x 14
(Memos useful cited +down from previous interview point - relate to less anxiety)
XPREN x 15

All felt now experienced to a certain extent. See **AFT7**
Personal strategies employed cited AFT11
RESCH x 0

BHE

ACDMC x 13
AFT7, 10 re :research ; AFT3 re: boudaries pushed
AFT5, AFT9
NURSG x 15
AFT11, AF 10, AF12 re: new standards: Made us change AFT1
TPSKL x 0 although x 4 cited critical skills **AFT4**
TEACHING ISSUES Aft2, student facilities AFT3, AFT8,
RESCH x 4
'Publish or perish!' still felt by 4 but down 6 from previous interviews ? relate to anxiety ↓
SELDV x 12 **Increased confidence AF5, AFT10, AFT14**
INCREASED STATUS x 4 ↓ x 5 from previous group
Increased options AFT13, AFT6, AFT9
Facilities x 4 ↑ AFT15 contract AF3
PROFESSIONALISM x 7 **AFT14, AFT6**
UNSUR x 0

PHE

NSKLS x 15 Much less **AFT2, AFT8, AFT10**
TEACH x 11 ↑ x 5 from previous interviews **AFT4, AFT5, AFT9, AFT10 AFT15**
TPSKL x 14 ↑ x 2 **AFT1, AFT4, AFT7, AFT8**
Increased workloads stated.
RLUNC x 13 Problem to do it with workloads/ Pressure to publish
RLEUN x 13 ↑ x 5 Turmoil **AFT14**
Support **AFT6, AFT8**
More demand on self but perceived as less stressful (relate to anxiety down) **AF5**
Increased different pressures **AFT7, AFT9, AFT10**

Less aware of students AFT1
Isolation x 7 AFT1
Qualifications versus improved care x 3 AFT2, AFT7, AFT13
Two-tiered system AFT$
Pressures ought to be more AFT5
Students attutudes AFT11
Skill loss AFT13
Lack of caring for one another AFT12 + less caring x 4 AFT15
Take over, not a merger **AFT10**

Appendix 20

Selected extracts from Stage 3 transcripts

j.c.
Interviewee 3.2

INTERVIEW SCHEDULE
QUALIFIED CLINICAL NURSES

1. **What is your current post?**
   Staff nurse - Grade E - Adult general medical ward
   How long have you been in that post?
   On ward 2 years but qualified 4 years
   Do you supervise students in your post?
   Mentor students both from college and university now

2. **What current contact do you have with nurse teachers/lecturers in nursing?**
   Do you call them nurse tutors or lecturers - Why?
   None at all now. I used to see them when they came to the ward but not now. The only contact I have is via the CPA documents and the students themselves. I call them nurse tutors or teachers because that's what they are!

3. **If you or another nurse on your ward have a student or educational problem/issue who do you contact - How/Why?**
   I'd probably report it to our ward sister and leave it with her because I wouldn't know who to contact now – they are all faceless if I'm honest. Recently we had a question about student study days and she rang the university allocations who were very helpful. I do think in an emergency the query contact line would be useful to improve communications

4. **What three attributes do you think are required for the role of nurse teacher. Do you feel the teachers you have met have these qualities?**
   I feel they have to be academically credible and be knowledgeable in their subject...Yes and up to date in their field, both in knowledge and clinical practice and be good at communicating. Most of them I have met and when I trained yes ... they had these qualities and they were always supportive.

5 **What do you understand of nurse training merging colleges of nursing with higher educational institutions?**
   I understand that students are now "supernumerary" and that they have more study days than when I trained which I think is useful for their studying. The problem is that they seem to have less money so do more agency to compensate. I'm also aware that the college has gone into the university and all nurse training takes place under that umbrella

6. What do you feel this has meant to the education/training of nursing?

Positive: *Well, I feel it should give nurses more status, credibility and recognition and more power as a group*

Negative: *The new breed of student nurses (and when they are qualified) are very different – they are much less practically orientated and they have limited skills for example assessment - which I find worrying. So I feel that more academia does not always mean better care and then we expect more of them ... such as this idea of critical thinkers and using evidence ... I think we expect too much'*

7. What do you feel this has meant to the practice of nursing?

Well, it should develop it – we were trained but I hope they get abit more out of education that we did and they should think things through more

8. Do you think that nurse teacher/lecturer role has/will change as a result of this merger?

Yes it already has. I worry that those who teach nursing are far removed from it all. At least in the college we did see tutors and although they sometimes acted as "trouble-shooters" they at least came to see us and seemed to value ward staff.

Now we get nothing and really hear very little so who is doing the teaching of the next generation of nurses and what are they being told.

9 If nurse teacher teachers/lecturers are to strengthen/improve their role as a result of nurse education/training in higher education - how might they best do this?

Well, talk more to us at grass roots and perhaps have clinical liaison forums.

I believe this is being developed but we need more so that this in turn strengthens their role (and nursing per say)

10. If clinical nurses are to develop as a result of the merger of education/ training into higher education - how might they do this?

Speak up more - being interviewed has given me an opportunity to say it e.g: so also liaison like this would help both sides

Appendix 20 continued

Stage 3 significant data identified by interviewees in theme groups

Contextual information

Clear in the expectations of the supervision role (15) Interviewees **3.1, 3.16,**
Clarity of need re: supervising role Interviewees **3.12, 3.18**
Unclear about nurse teachers role /title Interviewees **3.1, 3.3, 3.20**

Perceptions about the merger into higher education

Unclear re: merger event (17) Interviewees **3.20, 3.8, 3.18**
Problematic theory /practice gap (14) Interviewees **3.4, 3.1, 3.16, 3.15,3.18, 3.13, 3.3**
Content too theoretically based /not enough practice Interviewees **3.2, 3.9, 3.10**
Increased professional status (15) Interviewees **3.19, 3.17**
Better student facilities (10) Interviewees **3.7, 3.3, 3.4**
More educational opportunities (14) Interviewees **3.1, 3.7,**
Better academic qualifications (9) Interviewee **3.6, 3.14**
More research development (9) Interviewee **3.3, 3.13, 3.17**
Lack of clear focus/rising student numbers Interviewee **3.9, 3.5, 3.6**
Greater opportunities Interviewee **3.7, 3.19**
Greater pressures & expectations were high Interviewee **3.2, 3.20**

Perceptions of the nurse teacher role in higher education

Title - 'Nurse Tutors' at **all** times in interviews Interviewee **3.2, 3.1, 3.11, 3.9**

Nurse teachers need to be accessible (15), academically credible (13), clinically credible (14), approachable personality (11), be up to date (10), possess good communication skills (10) and be supportive (9), innovative and creative in the role (6), knowledgeable in the teaching of their subject (5) and be motivated and enthusiastic (3).
Interviewees **3.15, 3.5, 3.2**

Nurse teachers should be 'clinically credible' (14). Being more creative. ?Need clinical skills such as clinical visits (12) and actual clinical work (8) Interviewee **3.10, 3.14**
Time and support for such clinical activities (14)
Develop shared new posts between the university and trusts (10); nurse teachers more involved in the hospital activities both in meetings or interviews for staff (9) undertaking or advising about clinical research projects (8) and joint supervision of named students (4). Interviewee **3.14, 3.10, 3.7, 3.16,**
Confusion about nurse teacher title Interviewee **3.17, 3.6**

Communication with nurse teachers

Improve networking between university and clinical activities (10) Interviewee **3.7**
? Improve accessibility and communication pathways (20) Link role (16) **3.12, 3.8**
Information about the courses is a problem Interviewee **3.2, 3.8, 3.14**
Clinical initiatives Interviewee **3.7, 3.19, 3.10**
Contacts and communication Interviewee **3.6, 3.16, 3.9**
Troubleshooting Interviewee **3.2, 3.13**
Need to see nurse teachers directly Interviewees **3.17, 3.9, 3.4, 3.11, 3.10, 3.20, 3.18, 3.13.**